Linking Gender-Based Violence Research to Practice in East, Central and Southern Africa:

A Review of Risk Factors and Promising Interventions

February 2006

This publication was produced for review by the United States Agency for International Development. It was prepared by Myra Betron (consultant) and Elizabeth Doggett under the POLICY Project.

POLICY is funded by the U.S. Agency for International Development (USAID) under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000. The project is implemented by Futures Group in collaboration with the Centre for Development and Population Activities (CEDPA) and Research Triangle Institute (RTI).

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ACKNOWLEDGMENTS

The authors are extremely grateful to the following people for their high-quality, in-depth review of individual documents: Sarah Bott, Kathy Buek, Britt Herstad, Abigail Hollister, and Claire Wingfield. Thanks also go to Kay Willson, Tara Thomas, and *Raising Voices* in Uganda for providing data collection assistance. Without the help of each of these individuals, this report would not have been possible. In addition, a special thank you goes to Mark Wehling for his help in compiling the bibliography. Finally, many thanks go to Vathani Amirthanayagam, Sarah Bott, Rochelle Johnston, Ann McCauley, Jennifer Miguel, and Jeanne Ward for their comments and contributions, which were invaluable to completing this final report.

ABBREVIATIONS

AIDS – Acquired Immune Deficiency Syndrome
BCC – Behavior Change Communication
CDC – Centers for Disease Control and Prevention
CEDAW – Convention on the Elimination of All Forms of Discrimination against Women
CEDPA – Centre for Development and Population Activities
DHS – Demographic and Health Survey
ECPAT – End Child Prostitution, Child Pornography, and Trafficking of Children for Sexual Purposes
ECSA – East, Central, and Southern Africa
EU – European Union
FGC/M – Female Genital Cutting/Mutilation
FGMAP – CEDPA's Female Genital Mutilation Abandonment Project
GBV – Gender Based Violence
GDP – Gross Domestic Product
HIV – Human immunodeficiency virus
ICPD – International Conference on Population and Development
IEC – Information, Education, Communication
IGWG – Inter-Agency Gender Working Group
IPV – Intimate Partner Violence
IRC – International Rescue Committee
MAP – Men as Partners program
NGO – Non-governmental organization
PATS – The Project Against Trafficking and Sex and Gender Based Violence
PLWHA – People living with HIV/AIDS
PMTCT – Prevention of mother-to-child transmission (of HIV)
PSGR – People Serving Girls at Risk
REDSO – USAID's Regional Economic Development Strategy Office
RH – Reproductive Health
R.O.K. – Republic of Korea
SGBV – Sexual and Gender Based Violence
STD – Sexually transmitted disease
STI – Sexually transmitted infection
UNAIDS – Joint United Nations Program on HIV/AIDS
UNIAP – United Nations Inter-Agency Project on Human Trafficking in the Greater Mekong Sub-region
UNDP – Untied Nations Development Program
UNESCO – United Nations Educational, Scientific, and Cultural Organization
UNFPA – United Nations Population Fund
UNHCR – United Nations High Commissioner for Refugees (UN Refugee Agency)
UNICEF – United Nations Children's Fund
UNIFEM – United Nations Development Fund for Women
USAID – United States Agency for International Development
VAW – Violence Against Women
VCT – Voluntary counseling and testing
VFF – Visayan Forum Foundation
WHO – World Health Organization

I. EXECUTIVE SUMMARY

Gender-based violence (GBV) in Africa, as elsewhere in the world, is a complex issue that results from and is perpetuated by various facets of life, community, and society. As such, the ways to respond to and prevent gender-based violence must be just as multi-faceted, involving all sectors and members of the community and society. This report seeks to explain this complexity by summarizing the literature on risk factors and highlighting promising interventions related to gender-based violence in East, Central, and Southern Africa (ECSA). In so doing, the authors conducted an extensive review on the literature pertaining to risk factors and interventions for gender-based violence in 21 countries identified as priority countries for USAID's Regional Economic Development Strategy Office (REDSO) for ECSA and the UNICEF East and Southern Africa Regional Office. The countries are: Angola, Botswana, Burundi, Democratic Republic of Congo, Djibouti, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Rwanda, South Africa, Sudan, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.

In seeking ways to reduce and prevent gender-based violence, one cannot help but ask, "What are the causes of violence against women and girls?" Leading researchers in the region argue that the two essential factors underlying violence against women and girls are their subordinate status to men and the general acceptance of interpersonal violence in society, relegating the other factors as associated or mitigating factors (Jewkes, Levin and Penn-Kekanana, 2002). Women's low education or economic status, they argue, are correlated to their unequal status in society, which when challenged, cause men to react with violence against women. The vicious cycle is hard to break even if a woman has some economic independence, as socio-cultural norms and laws make it difficult for women to leave their violent partners. Challenging this unequal status can be even more difficult for younger women. Moreover, the conflict over resources that comes as a result of poverty may be mediated through violence where violence is the norm. In turn, where violence against women is normative, sanctions against violent men, both social and legal, are usually low. Finally, alcohol abuse clearly correlated to violence, acts, at times, as a trigger for violence by increasing the likelihood for conflict and reducing inhibitions.

Few programs addressing gender-based violence have been rigorously evaluated. Instead, there are a handful of promising interventions in the health, justice, education, and community development sectors that, if collectively supported and implemented, could have even more meaningful impacts on the prevention of GBV. These include: (i) a systems approach to reforming health services, from implementing policies and protocols to address violence to the training of providers and provision of specific GBV needs; (ii) sensitizing and training police so that they better respond to reports of GBV; (iii) strengthening schools through policies that do not tolerate violence perpetrated by teachers or students and through capacity-building of teachers and students on principles of gender equity and its role in GBV; and (iv) community mobilization—through television, radio, community forums, drama, and other popular media—and individual behavior change efforts across all sectors in order to change attitudes and ultimately, behavior related to GBV. Effecting these changes and ensuring their sustainability means that the foundation for each of these interventions is gender sensitization to promote gender equity, as well as increased understanding of GBV as a human rights problem that is detrimental to the community as a whole. Other crosscutting conclusions include:

- *A multisectoral approach* that pools efforts from a variety of fields of work is essential in preventing and responding to gender-based violence. Each field or sector has its role to play in helping survivors of GBV and preventing incidents of GBV: health providers detect cases and treat survivors while promoting healthy relationships through sexual and reproductive health programs; law enforcement puts sanctions on perpetrators of GBV; and educators impart the message that GBV is a violation of human rights and should not be tolerated or perpetrated. It is imperative that these roles are coordinated to be fully effective.

- A *multi-level approach* (individual, community, institutional, national, and international) must be taken in any and all sectors addressing GBV. Common sense practically dictates that changing individual behavior, mobilizing communities, reforming institutional response, as well as reforming laws and policies are all vital strategies to challenging this multi-faceted problem.

- *Top-down as well as bottom-up* leadership and mobilization are necessary. Activities that mobilize citizens of communities *and* engaged leaders in the community are especially successful in changing attitudes and, at least according to preliminary findings, behavior. Without support from ministries or municipal leaders, however, interventions are less likely to be taken seriously and at times not fully carried out.

- *Working with men* is a key strategy. Throughout the review, examples made evident that working with men is a key strategy to prevent gender-based violence. Behavior change strategies in the health sector have shown that gender inequitable attitudes can be unlearned. In schools, focusing initiatives on girls as "victims" to be protected without addressing patriarchal attitudes and behavior among boys simply reinforces the notion that girls are responsible for the violence they suffer. Throughout society and the community in general, men are decision makers that can pave the way for change.

- *Targeting youth* is perhaps one of the most efficient ways to prevent gender-based violence, albeit in the longer term. Evidence suggests that youth are more open to change, including their attitudes and behavior regarding violence. (Bott, Morrison, and Ellsberg). Nonetheless, such strategies should not undermine the need to work with the community overall.

- To promote community ownership of GBV as a problem, *community mobilization should involve all members of the community*, from civilian beneficiaries, to health and legal service providers, teachers, and community leaders. Individual behavior change is not enough; it must be linked to and reinforced by norms and messages in the surrounding community in order to be sustainable.

- *Preventing gender-based violence is a long-term investment.* Raising awareness is only the beginning of the processes of influencing change (Michau and Naker, 2004). Individual behavior change and community mobilization, as experiences of many programs reviewed made evident, requires long-term follow-up that may take years. Additionally, helping individuals think through alternatives to violence and creating informal and formal systems of accountability and support are essential for individuals to sustain a change in attitude and behavior (Michau and Naker, 2004). Too often, however, limited funding allows for only short-term support.

While the dearth of existing information illustrates the need for increased research on risk factors and promising interventions for gender-based violence, much can be done to stop the problem now. The victims of GBV who are suffering in silence at the hands of their perpetrators can no longer wait for the "best" approach. As much as the above findings are salient and should be implemented to the extent possible, the urgent nature of GBV, whose victims' lives are at risk, begs communities—local, national, and international—to act immediately.

II. INTRODUCTION

OBJECTIVES

Gender-based violence is a pressing problem not only because it violates human rights but also because it poses a challenge to public health and economic and social development. Although researchers, policymakers, and program designers in the public health and human rights arenas recognized this fact as early as 20 years ago, the field of international development has only seriously acknowledged it within the past decade. Even then, efforts have been small, isolated, under-funded, and limited to specific regions or countries that have been graced with proactive feminist leaders and practitioners in the field. In Africa, where the issue of gender-based violence has long been a flagship theme for feminist leaders of the region, donors have only begun to take it seriously as a development priority in recent years.

Gender-based violence in Africa, as elsewhere in the world, is a complex issue that is influenced by various facets of life, community, and society. As such, the ways to respond to and prevent gender-based violence are just as multi-faceted, involving all sectors and members of the community and society. From a public health perspective, this report seeks to explain this complexity by summarizing the literature on risk factors and highlighting promising interventions related to gender-based violence in East, Central, and Southern Africa (ECSA) in order to better inform a strategy on GBV for USAID's Regional Economic Development Strategy Office (REDSO) and the regional offices of UNICEF, UNFPA, and UNIFEM. This strategy will guide GBV programming in the region for these agencies. Priority countries identified for this review by USAID and UNICEF include Angola, Botswana, Burundi, Democratic Republic of Congo, Djibouti, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Rwanda, South Africa, Sudan, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. Please note that while the ECSA region as defined here is comprised of 21 countries, available data are found primarily in Ethiopia, Kenya, Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe. Nonetheless, it is hoped that with the base of knowledge provided in this report, donors will be able to design informed strategies to address gender-based violence in the region.

SCOPE

This report particularly focuses on intimate partner and sexual violence (especially in the context of intimate partners but also outside of partnerships), since these forms of violence are widespread in each of the countries in ECSA. The report also briefly examines female genital cutting, sex trafficking, early marriage, and violence amongst men and boys as an expression of traditional masculinity. Although these forms of GBV are also relevant in the ECSA context, they are the topics of other recently or soon to be released literature reviews for the region.[1]

METHODOLOGY

This review was performed using sources identified on POPLINE,[2] MEDLINE,[3] Ingentaconnect,[4] numerous databases linked to FirstSearch,[5] as well as searching over 20 organizational websites for

[1] For FGC/M, see Bodiang, Claudia Kessler. 2003. "Promotion of Initiatives to End Female Genital Mutilation." GTZ. For trafficking, see IOM. 2005. *Data and Research on Human Trafficking: A Global Survey*. International Organization for Migration: Geneva, Switzerland. For early/child marriage, USAID has commissioned the International Center for Research on Women to conduct a literature review that is expected to be released later this year. Finally, for violence against boys and men, research is still emerging and much more needs to be done. However, this report relies heavily on Barker, Gary and Ricardo, Christine. 2005. "Young Men and the Construction of Masculinity in Sub-Saharan Africa: Implications for HIV/AIDS, Conflict and Violence." Social Development Papers, Conflict Prevention and Reconstruction. Paper No. 26. World Bank: Washington, DC.

[2] http://db.jhuccp.org/popinform/basic.html

relevant documents. (For a complete list of the databases searched through FirstSearch and websites searched, see Annex 3.) In searching these databases, the following terms were used: gender-based violence, violence against women, intimate partner violence, sexual violence, rape, early marriage, and bride price.

This search was complemented by various existing literature reviews done on GBV in developing countries in recent years. A list of these reviews can be found in Annex 4. Several of these reviews focus on one particular sector or type of violence or look primarily at interventions to address GBV. They were nonetheless invaluable in conducting this review.

Since much research on gender-based violence remains unpublished, especially with respect to promising interventions, this review relies heavily on the Grey literature (informally published documents) collected through Non-Governmental Organizations (NGO) and donor contacts in the field, especially the USAID Africa bureau. Nonetheless, the literature on GBV is constantly growing, and numerous documents were unavailable to the review team for a variety of reasons. Consequently, it is certain that some research on GBV risk factors and promising interventions has not been included in this report.

Finally, studies reviewed on risk factors in ECSA were limited to those that involved some form of primary research (e.g., surveys, clinical trials, focus groups, or interviews), whether qualitative or quantitative. Documents reviewed on promising interventions were limited for the most part to those that were evaluated or at least reviewed in a systematic manner, either quantitatively or qualitatively. In addition, interventions discussed focused on or tied primarily to prevention. Finally, it is important to note, once again, that the review is written from a public health perspective and as such, examines risk factors from biological, psychological, social, and other environmental contexts, as opposed to just cultural determinants as an anthropological perspective might, or socio-cultural gender issues, as a feminist perspective might.

HOW THE REPORT IS ORGANIZED

As mentioned above, the scope of this review focuses on two forms of GBV in particular: intimate partner violence and sexual violence. Intimate partner violence and sexual violence are discussed concurrently throughout most of the paper, using the same frameworks as these two types of violence often go hand-in-hand (Jewkes, 2002) and have very similar risk factors (Krug et al., 2002) and interventions to address them. Some forms of sexual violence outside of intimate partnerships, particularly sexual violence relating to transactional sex or sexual violence in conflict situations, are distinct in nature, and, thus, are discussed in proceeding sections, as are early marriage, female genital cutting, and human trafficking. The report first summarizes factors that enable and perpetuate these types of violence in the ECSA region. It then attempts to link these risk factors to promising interventions to address and prevent GBV in the region. Violence against children, violence against men and boys, and GBV in conflict settings are rather distinct topics from intimate partner and sexual violence; thus, the report addresses these topics in separate boxed pages.

[3] http://www.ncbi.nlm.nih.gov/entrez/query.fcgi
[4] www.ingentaconnect.com
[5] http://www.oclc.org/firstsearch

III. GENDER-BASED VIOLENCE IN ECSA: AN OVERVIEW

WOMEN'S RIGHTS IN ECSA

The progressive political changes of the last 50 years, coupled with the rich, cultural and familial traditions in ECSA create a complex and sometimes paradoxical environment for women at the policy, community, and family levels. International governing bodies have had some limited influence through legal treaties (see Box 1), but for the most part, effectiveness and enforcement of these laws is non-existent.

Box 1. International Conventions that Address Gender-based Violence

- **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**—states that men and women have equal rights in every sphere, including the workplace, education, sports, health care, financial rights, legal rights, marriage and divorce, and parenting.
- **Convention on the Rights of the Child**—defines a child as 18 years or younger unless the age of majority is reached earlier; forbids all forms of violence against children including child abuse and exploitation as well as discrimination based on gender.
- **The Optional Protocol on the sale of children, child prostitution, and child pornography**—prohibits the sale of children, child prostitution, and child pornography; criminalizes those involved at any stage in the exploitation of children; provides measures to deal with the transnational dimensions of the commercial sexual exploitation of children; and asserts that exploited children are to be treated as victims not criminals.
- **The African Charter on the Rights and Welfare of the Child—**sets many of the rights in the CRC within an African context; prohibits customs and practices that compromise the health of the child and/or that are discriminatory to the child on the grounds of sex; and sets the minimum age of marriage at 18 years.
- **International Labor Organization Convention No. 182**—forbids the worst forms of child labor and trafficking.
- **International Covenant on Civil and Political Rights**—establishes all people's right to be recognized as a person under the law; equal rights between spouses; forbids sex discrimination.
- **International Conference on Population and Development (ICPD) Program of Action**—establishes rights to sexual and reproductive health.
- **Human Rights Committee, General Comment #28**—dictates that women cannot be inherited as property.
- **African Charter**—gives women the right to property.
- **Universal Declaration of Human Rights**—establishes the equal rights of all people; requires consent for marriage; establishes the right to marry and divorce and to own property, as well as the right to be free from torture and mistreatment.
- **Convention Relative to the Protection of Civilian Persons in the Time of War**—forbids rape, forced prostitution, or indecent assault on women (Human Rights Watch, 2003).

National and local policies around women and gender-based violence, including inheritance rights policies, marriage and divorce laws, domestic and sexual violence laws, and laws around cultural practices such as female genital cutting (FGC/M) and early marriage vary widely. Many countries recognize both constitutional and traditional legal systems, even though the two often contradict each other, and the power of and boundaries between the two are not always clear (Armstrong, 1998; Benninger-Budel, 2000; Center for Reproductive Law and Policy, 2001). Laws range from some of the

world's most progressive, such as South Africa's Gender-Based Violence Policy and Zambia's National Gender Policy (Benninger-Budel, 2000; Bourke-Martignoni, 2002) to nonexistent, such as ignoring the reality of marital rape in Zambia, Tanzania, Ethiopia, and Kenya (Martinez, 1998; Bourke-Martignoni, 2002; CRLP, 2001), to downright exploitative, such as Tanzania's age of marriage laws, in which provisions exist that permit girls as young as 12 years-old to legally marry (Martinez, 1998).

Similarly, the extent to which the laws are implemented varies, particularly at the community level. There are many reasons for poor implementation of woman-friendly policies, including low political commitment or popular support at the local level, conflict between traditional and constitutional law, and lack of training for institutional staff in the policies and protocols, sometimes due to budgetary constraints, among others.

Furthermore, women may not have access to the information necessary to recognize their rights and to negotiate the legal system if they feel that their rights have been violated. It is in this context that convicting perpetrators of GBV is difficult. Studies in South Africa and Zambia, for example, have shown that legal systems rarely convict rapists and that often the courts side with the perpetrator instead of the victim by making excuses for him (Rude, 1999; Benninger-Budel, 2000). In fact, recent international reports have revealed that traditional courts and community justice systems sometimes blame the victim for rape and, consequently, shun her from the community. (See Amnesty International, 2004c).

In some areas, women are generally seen as property to be sold, inherited, and controlled. For example, Halim argues that women in Northern Sudan use the term "nihna bahaim," meaning "we are cattle," to describe themselves and their status of being "saleable, disposable, replaceable, not individuals but property to be acquired" (Center for Women's Global Leadership, 1994). Focus groups in South Africa maintained that the practice of bride price upholds the belief that women are property and can be bought and sold (Kim, 2002). Ward argues that in Sudan, too, bride price serves to label women as men's property (Ward, 2005). Bride price, which is practiced throughout the ECSA region, may contribute to social norms that excuse violence against women, as husbands may feel entitled to beat or rape their wives because they paid for them (Bourke-Martignoni, 2002; Kim and Motsei, 2002; Ward, 2005). For example, research from South Africa suggests that many men see sex with their wives and girlfriends as their right and consider use of force as an acceptable means of initiating it (Wood and Jewkes, 2001).

Not only are women sometimes treated as property, but they also face many obstacles in owning and inheriting property because of legal and cultural reasons (Benninger-Budel, 2002). In some cases, lack of property rights increases women's dependence on men, making it especially difficult for women to leave abusive relationships (Strickland, 2004).

PREVALENCE AND NATURE OF COMMON FORMS OF GBV

Gender-based violence is "any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females" (IASC, 2005). Gender-based violence has a greater impact on women and girls as they are most often the victims and suffer greater physical damage than men when victimized (WHO a, 2005). In fact, the term "gender-based violence" is often used interchangeably with the term "violence against women."[6] The term gender-based violence is also used to point to the dimensions within which violence against women takes place; women's subordinate status (both economic and social) make them more vulnerable to violence and "contribute to

[6] The United Nations General Assembly defined violence against women as "Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering for women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life" (United Nations General Assembly, 1993).

an environment that accepts, excuses, and even expects violence against women" (Heise et al., 1999). It is important to recognize, however, that in some circumstances, men and boys also are victims of GBV, such as rape as a method to de-masculinize men or boys. Gender roles also contribute to the fact that men and boys not only feel pressured by their male peers to express their masculinity through acts of violence against women, but also against other boys and/or men, as is often the case with gang violence. Given the overwhelming evidence that GBV disproportionately affects women, however, this review focuses primarily on GBV against women.[7]

Intimate Partner Violence

Intimate partner violence is defined as "any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. Such behavior includes:

- Acts of physical aggression—such as slapping, hitting, kicking, and beating.
- Psychological abuse—such as intimidation, constant belittling, and humiliating.
- Forced intercourse and other forms of sexual coercion.
- Various controlling behaviors—such as isolating a person from their family and friends, monitoring their movements, and restricting their access to information or assistance" (Krug et al., 2002).
- Economic abuse—such as with-holding funds or controlling victim's access to health care or employment (WHO, 2005a).

Data on the prevalence of GBV in the ECSA region is limited. Most studies have measured physical and sexual violence in the context of intimate partnerships. Survey data (Table 1) and anecdotal evidence suggest that these forms of GBV are common in nearly all settings in the region. Yet women's perceptions of violence as a normal and acceptable part of their lives pose a challenge for prevalence studies that measure GBV, as women may not recognize violence and, therefore, under-report experiences of it. Thus, the most reliable population-based studies tend to question women about specific practices, such as being slapped, pushed, or forced to have sex against their will, rather than asking women if they have been "abused" or "raped" (Heise et al., 1999). However, the stigma surrounding intimate partner violence causes many women not to report their victimization despite the research methodologies used. Many countries depend on cases reported to health centers or police for data, but health and legal services are often so weak or scarce that women do not seek their services. In short, survey statistics, as well as the health or criminal justice systems, underestimate the true extent of the problem.

Because of variations in the ways intimate partner violence is defined or because of differences in variables measured, comparing results from different studies is difficult and often impractical. Other factors which make data incomparable include variations in selection criteria for study participants, differences resulting from the sources of data and methods of collection, and the willingness of respondents to talk openly and honestly about experiences with violence (Krug et al., 2002).

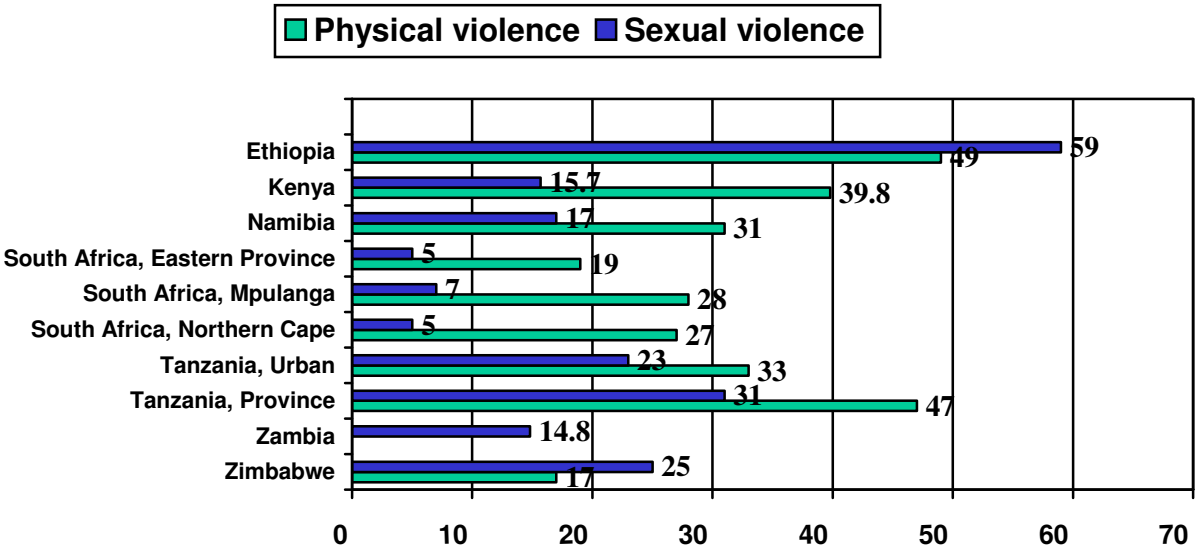
Still, a look at survey data reveals that it is a major problem in ECSA countries. Population-based studies on IPV in Ethiopia, Kenya, Namibia, South Africa, Tanzania, Zambia, and Zimbabwe have found

[7] Researchers, policymakers, practitioners, activists, and the general public use gender-based violence to describe a variety of forms of GBV, including violence against women, domestic violence, intimate partner violence, and family violence. Throughout the report, the type of violence discussed is specified to the extent possible with precise terms. Throughout the report, the terms violence against women, gender-based violence and intimate partner violence are sometimes used interchangeably, as done in various studies reviewed, but only after establishing intimate partner violence as the topic of focus. When discussing sexual violence only, or other forms of GBV, the report explicitly uses those terms.

that 13–57 percent of women report having been physically assaulted by a partner at some point in their lives (see Figure 1). Population-based studies on sexual violence in Ethiopia, Kenya, Namibia, Tanzania, Zambia, and Zimbabwe estimate that 14–59 percent of women have experienced sexual violence at some point during their lives (see Figure 1). Studies worldwide indicate that, in one-third to one-half of cases, physical violence against women by their intimate partners is accompanied by sexual violence (Heise et al., 1999). Similarly, studies have reported that many women who experience physical aggression by their husbands or partners experience multiple acts over time (Heise et al., 1999).

Throughout the ECSA region, researchers have found that large proportions of women and men see violence as a common, acceptable means for men to "punish" their female partners. Such punishment is justified usually by behaviors that transgress local gender norms, such as refusing sex with a husband, arguing with a husband, not performing household duties, talking back, or not asking permission to do something such as leave the house (Armstrong, 1998; Best, 2005; Heise et al., 1999; Jewkes et al., 2001; Jewkes, 2002; Kim and Motsei, 2002; Moffett, 2001; Njovana and Watts, 1996; Rude, 1999; Wood and Jewkes, 2001).

Figure 1. Percentage of women who reported physical violence and sexual violence by an intimate partner (ever)



Source: Various population based studies (1996–2005).
Ethiopia: WHOb, 2005; Kenya: Central Bureau for Statistics Kenya and ORC Macro., 2003; Namibia: WHOb, 2005; South Africa: Jewkes et al., 1998 cited in Heise, Ellsberg and Gottoemeller, 1999; Tanzania: WHOb, 2005; Zambia: Central Statistics Office Zambia and ORC Macro, 2003; Zimbabwe: cited in Krug et. al., 2002.

Sexual Violence and Coercion

Sexual violence is "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (Krug et al., 2002).

One of the most common forms of sexual violence in the world is intimate partner sexual violence (Krug et al., 2002), which is presented in the data above. Research on other forms of sexual violence is even more limited than data on intimate partner violence (IPV). As with IPV, most data come from police or medico-legal clinics, which really just represent the "tip of the iceberg" in that these are

usually the most severe cases by the small proportion of women who were willing to report their cases (Jewkes and Abrahams, 2002). While there have been a handful of surveys done on sexual violence in the region, the definitions of abuse have varied—if defined at all. Data from international crime surveys that use a common methodology found that the prevalence of women (16 or older) who reported sexual assault between 1992 and 1997 was 2.3 for South Africa, 4.5 for Uganda, and 2.2 for Zimbabwe (Krug et al., 2002). These data reflect a common belief in the region that forced sex by intimate partners does not constitute sexual abuse, as studies show that as many as one in four women in Uganda, for example, experience forced sex in intimate partnerships (Koenig et al., 2004), while in Kenya, 21 percent of female adolescents 10–24 years-old (and 11 percent of males) experienced sexual coercion (Erulkar, 2004).

Likewise, forced first intercourse, has also been found to be just as high. In South Africa, for example, 32 percent of pregnant adolescents attending an antenatal clinic in Capetown said that force was used during their sexual initiation (Jewkes et al., 2001). In Mwanza, Tanzania, nearly 30 percent of female adolescents ages 12–19 (and 7 percent of males) had experienced forced sexual initiation (Krug et al., 2002).

Research on the various forms of sexual coercion, from harassment in schools to certain types of transactional sex, is still quite limited. Research is complicated by the fact that the distinction between sexual violence/abuse, sexual coercion, and what some would call "cultural or social norms," particularly for cross-generational relationships (discussed below), is not always so clear. Indeed, sexual coercion can involve sexual violence as it can include physical force. As defined by Heise, Moore, and Toubia (1995), sexual coercion is "*The act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in sexual behaviour against her/his will... it includes a wide range of behaviours from violent forcible rape to more contested areas that require young women to marry and sexually service men not of their choosing."* Due to this overlap, this review has put information on sexual violence (outside of intimate partnerships) and coercion in the same sections.

Sexual coercion is perhaps an even more widespread phenomenon in the region as qualitative evidence suggests. A common phenomenon found throughout sub-Saharan Africa, which is also tied to poverty, is the "sugar-daddy effect"—wherein girls are seduced into cross-generational sexual relationships in exchange for money and/or gifts. A review of cross-generational sex among girls (ages 15–19) found that on average, girls' sexual partners in sub-Saharan Africa are 6 years older than them (Luke and Kurz, 2002). A significant percentage of girls, for example, 11.8 percent in the Rakai District of Uganda (Kelly et al., 2001) and 33 percent in urban Tanzania (Komba-Malekela and Liljestrom, 1994), have sexual partners 10 or more years older than themselves. The review also found that as girls mature, the age difference between themselves and their partners tends to increase (Luke and Kurz, 2002).

Further research is necessary to better understand the inter-relationship between the sugar-daddy effect and IPV. While we do not yet know whether or not girls in cross-generational relationships are more vulnerable to violence, differences in power between young people and their adult sexual partners and transactional sex, if at least one of the partners is still legally a child, are themselves exploitative. In many countries in the region, young people cannot legally consent to sexual relations (usually with someone older than them) until they reach a certain age (varies according to the country). Furthermore, according to the Optional Protocol on the sale of children, child prostitution and child pornography (the use of a child in sexual activities for remuneration or any other form of consideration) is prohibited, meaning that people under the age of 18 cannot consent to transactional sex. Thus, any sexual activity that falls under these two categories is increasingly becoming recognized as a form of violence (Johnston, February 2006 e-mail).

Girls in numerous studies in countries as diverse as Botswana, Ethiopia, Kenya, Malawi, Tanzania, South Africa, Sudan, Uganda, and Zimbabwe report that sexual harassment and sexual assault, primarily from teachers and male students, are widespread and accepted by authorities in the school setting—from primary school to the university level (Mulugeta et al., 1998; Mirsky, 2003; Leach, 2002; Omaar and DeWaal, 1994; Rosetti, 2001; Mirembe and Davies, 2001). In war-torn and refugee settings of the ECSA region, women and girls are also at increased vulnerability to GBV (Raven-Roberts, 1996; Akeroyd, 2004; Ward, 2002). In recent times, rape has been recognized and criticized by researchers, activists, and the media as a weapon of war (Askin, 1999; Human Rights Watch, 2003).

Early Marriage

Early marriage is the marriage of a person at an age at which she/he is not fully able to consent to the marriage and/or marriage at an age which results in vulnerability to reproductive health problems, psychosocial damage, or denial of education. Many married children and adolescents have been forced into marriage or may be "too young to make an informed decision about their marriage partner or of the implications of the marriage itself" (UNICEF, 2001). Early marriage covers a broad range of experiences; girls married at age 10 certainly have different experiences of marriage than girls married as teenagers. In some areas, girls are married extremely early. For example, in the Amhara region of Ethiopia, 14 percent of girls are married by age 10 and 39 percent are married before age 15 (Erulkar et al., 2004). According to international standards, neither informed sexual consent nor consent to marry can be present at this age (UNICEF, 2001). Although girls married this young do not always consummate their marriages right away, age at first intercourse still tends to be early; the same study in Amhara, Ethiopia, showed that 8 percent of married girls had sex by age 10, 26 percent by age 12, and 70 percent by age 15 (Erulkar et al., 2004). While boys and girls may experience early marriage, girls are much more likely than boys to be married early. Legal marriage age is often lower for girls than for boys (Erulkar et al., 2004) and marriage age is often not fully enforced due to contradictions between civil and customary laws pertaining to marriage (Ansell, 2004).

Early marriage can include forced marriage of a child or adolescent, or of a seemingly consensual marriage in which one or more partners is too young to fully understand the implications of the decision to marry. In Amhara, Ethiopia, for example, even among girls married after the age of sexual consent, the majority "did not know about the impending marriage and less than half wanted to marry or consented to it" (Erulkar, 2004). Furthermore, having reached age of sexual consent does not necessarily mean that all married girls at this age consent to sex; only 2 percent of married girls surveyed in the same Ethiopian survey reported participating in the decision to have sex for the first time; whereas, 82 percent of married girls "would have preferred not to have sex when they did and 81 percent were forced to have sex against their will" (Erulkar, 2004).

In ECSA, the practice of early marriage is quite widespread. In sub-Saharan Africa, between 50 and 60 percent of women are married before age 18 (Jensen and Thornton, 2003). Early marriage has "profound physical, intellectual, psychological, and emotional impacts, cutting off educational opportunity and chances of personal growth. For girls…it will almost certainly mean premature pregnancy and childbearing, and is likely to lead to a lifetime of domestic and sexual subservience over which they have no control" (UNICEF, 2001). Early marriage is a risk factor for GBV, but is also a form of GBV in itself because of the physical, psychosocial, and emotional damage it can cause to girls married too young.

Box 2. Violence Against Children

Gender-based violence also affects children[8] and young people. Child abuse can be defined as "*all forms of physical and/or emotional ill treatment, sexual abuse, neglect or negligent treatment, or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development, or dignity in the context of a relationship of responsibility, trust, or power"* (WHO in Zuberi/UNICEF, 2005). While gender-based violence—for example sexual harassment or the assault of girls by boys—may be perpetrated by peers, it may also be perpetrated by adults against children. Thus, age as well as gender is used to control and oppress. While a girl may struggle to resist unwanted sexual advances from a classmate, she is far more powerless to resist the same from a male teacher or, as is more often the case, her own father.

Violence against children can occur in homes, in schools, in workplaces, in the streets, and in custody/residential institutions (Zuberi/UNICEF, 2005). It can be manifested through physical violence (including corporal punishment), sexual violence or harassment, emotional abuse, neglect, and harmful traditional practices, among others (Zuberi/UNICEF, 2005). There are gender dimensions to each of these types of abuses, but perhaps the most gender-based form of child abuse is sexual abuse and exploitation. Studies consistently show, for example, that in the case of female victims of sexual abuse, over 90 percent of the perpetrators are men, and in the case of male victims, between 63 and 86 percent of the perpetrators are men (Krug et al., 2002).

Certain forms of GBV, such as sexual exploitation, nonconsensual sex with children, and early marriage are by definition committed against children. Female genital mutilation/cutting is nearly always perpetrated against girls. In many communities, other forms of GBV, such as human trafficking, disproportionately affect those under the age of 18. Age-based oppression is even a factor in peer-on-peer GBV. The fact that adults, both men and women, often condone this type of violence impedes young people's efforts to realize greater gender equality.

It is beyond the scope of this review to look at specific risk factors and promising interventions for child abuse. It can be said that most of the risk factors and promising interventions for child abuse are the same or similar to those for IPV and sexual violence. However, care must be taken to address the special needs and vulnerabilities of children. For example, protocols and trainings for a health sector response to GBV against adult women are not appropriate for young children or adolescent girls. The different legal status of these groups, particularly in relation to giving consent for medical treatment, presents a host of challenges that need to be resolved through protocols and institutions that are centered on the realization of children's rights (Johnston, February 2006 email). Additionally, health professionals need to be trained in children's rights as well as in children's development.

Female Genital Mutilation

Female genital cutting (FGC/M) is the "full or partial removal of girls' external genitals, often performed under dangerous, unsanitary conditions and without anesthesia, for cultural or non-therapeutic reasons" (World Health Organization, 2000). As stated in USAID's Bureau for Global Health Strategy for Female Genital Cutting, "FGC violates a young girl's right to reproductive health, and gravely harms her

[8] For the purposed of this report the definition of a child found in the UN Convention on the Rights of the Child as a person under the age of 18 is used. The words young person and youth lack similar legal definitions but are used to refer to adolescents and young adults.

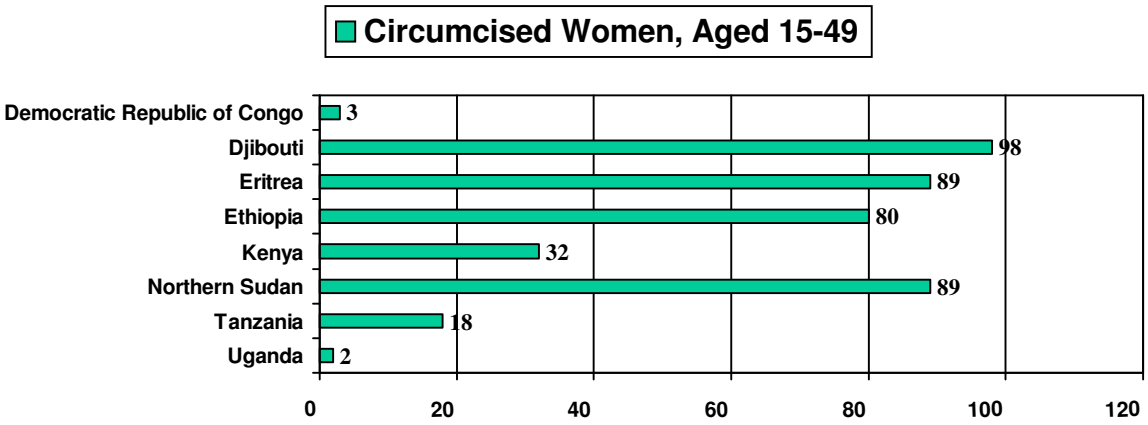
physical and mental health" (Bureau for Global Health, 2004). The WHO has classified FGC/M into four categories (WHO, 1999):

- Type I—Excision of the prepuce with or without excision of part or all of the clitoris.
- Type II—Excision of the prepuce and clitoris together with partial or total excision of the labia minora.
- Type III—Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
- Type IV—Unclassified: Pricking, piercing, or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina; introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure that fall under the definition of female genital mutilation given above.

FGC/M is generally performed on girls between ages 4 and 12, although it is practiced in some cultures as early as a few days after birth or as late as just prior to marriage, during pregnancy, or after the first birth (PRB, 2005). Typically, traditional elders (male barbers and female excisors) carry out the procedure, sometimes for pay (PRB, 2005). Thus, the practitioner often does not have health training, use anesthesia, or sterilize the cutting instruments. Instruments used for the procedure include razor blades, glass, kitchen knives, sharp rocks, scissors, and scalpels. In some cases, it is not remuneration but the prestige and power of the position that compels practitioners to continue (PRB, 2005).

In the ECSA region, the prevalence of FGC/M ranges from 2 percent of women in Uganda to 98 percent in Djibouti (Bureau for Global Health, 2004) (see Figure 2). Countries in ECSA that practice FGC/M include Djibouti, Eritrea, Sudan, Ethiopia, Kenya, Tanzania, the Democratic Republic of Congo, and Uganda.

Figure 2. Percentage of women who have been circumcised in ECSA countries



Source: Bureau for Global Health, 2004

Human Trafficking

Human trafficking is comprised of "the recruitment, transportation, transfer, harboring, or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of

deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs" (UN in State Department, 2005).

Trafficking in women and children, which consists largely of sex trafficking, has recently received growing interest and attention as a human rights violation and as a form of GBV. In fact, the US State Department considers sex trafficking a "severe" form of trafficking. It reports that each year, approximately 600,000 to 800,000 men, women, and children are trafficked across international borders, and of that number, an estimated 80 percent are women and girls, most of which are trafficked into commercial sex exploitation (U.S. Department of State, 2005). In a UNICEF (2003) survey, countries in ECSA reported being both countries of origin and destinations. Thirty-three percent of countries in East and Southern Africa reported that trafficking is a problem in their countries and is considered a particular problem in Central Africa (UNICEF, 2003). It is important to recognize that these are broad statistics. Accurate data are difficult to collect because of the underground nature of the phenomenon and the lack of a precise definition for trafficking (UNIFEM/UNIAP, 2002).

Most research on the extent of the trafficking problem is qualitative in nature. A recent review by the International Organization for Migration (2005) sheds some light on the patterns of trafficking worldwide: in East Africa, young girls and women abducted from conflict zones are forced to become sex slaves to rebel commanders or affluent men in Sudan and the Gulf States; South Africa is a destination for regional and extra-regional trafficking activities; finally, women are trafficked through the network of refugees resident in South Africa and trafficked from Thailand, China, and Eastern Europe to South Africa. Women and children are trafficked to Europe (Italy, Germany, Spain, France, Sweden, UK, and the Netherlands) for commercial sex.

HEALTH IMPACTS OF GENDER-BASED VIOLENCE

Although violence can have direct health consequences, such as physical injury, evidence suggests that experiencing violence also increases a woman's risk of future ill health (Krug et al., 2002)—for example, through harmful behavioral outcomes like drug and alcohol abuse or unsafe sexual practices. International and ECSA-based research shows that women who experience physical and/or sexual abuse by an intimate partner experience ill-health more frequently than other women—with regard to physical functioning; psychological well-being; and the adoption of further risk behaviors, including smoking, physical inactivity, non-use of contraceptives and condoms, and alcohol and drug abuse (Krug et al., 2002; Koenig, 2004) (see Table 1).

Table 1. Health Consequences of Intimate Partner and Sexual Violence

Fatal Outcomes	Non-Fatal Outcomes		
	Physical injuries and chronic conditions:	Sexual and reproductive sequelae:	Psychological and behavioral outcomes:
• Femicide • Suicide • AIDS-related mortality • Maternal mortality	• Fractures • Abdominal/thoracic injuries • Chronic pain syndromes • Fibromyalgia • Permanent disability • Gastrointestinal disorders • Irritable bowel syndrome • Lacerations and abrasions • Ocular damage	• Gynecological disorders • Pelvic Inflammatory disease • Sexually-transmitted infections, including HIV • Unintended pregnancy • Pregnancy complications • Miscarriage / low birth weight • Sexual dysfunction • Unsafe abortion	• Depression and anxiety • Eating and sleep disorders • Drug and alcohol abuse • Phobias and panel disorder • Poor self-esteem • Post-traumatic stress disorder • Psychosomatic disorders • Self harm • Unsafe sexual behavior

Source: Bott, Morrison, and Ellsberg, 2005.

The consequences of FGC/M for the health of women can be severe, including obstetric problems (antenatal, labor, delivery, post partum, pregnancy outcome, maternal mortality, and neonatal mortality); gynecological problems, such as menstrual problems; psychosexual problems, such as infertility and urinary problems; and psychological morbidity (WHO, 2000). Given these serious and sometimes fatal impacts of FGC/M, its significance as a form of GBV should not be overlooked. Human rights concerns aside, the documented impacts on maternal and child health are plentiful as evidenced by the box below.

Table 2. Maternal and Child Health Consequences of FGC/M

Obstetric Sequelae of FGC/M in Earlier Life		Childbirth Sequelae of FGC/M in Pregnancy	
Antenatal Effects: ▪ Pregnancy in presence of pinhole introitus ▪ Fear of labor and delivery due to small size of introitus ▪ Difficulty in performing antenatal vaginal examination ▪ Painful scar	Effects During Labor and Delivery: ▪ Urine retention during labor ▪ Difficulty assessing progress of labor ▪ Prolonged labor and/or obstruction ▪ Fetal distress ▪ Episiotomies and perineal tears ▪ Postpartum hemorrhaging ▪ Maternal death ▪ Fetal death ▪ Post-partum genital wound infection	Antenatal Effects: ▪ Hemorrhaging ▪ Infection ▪ Fetal injury	Effects During Labor and Delivery: ▪ Pre-term labor ▪ Obstruction requiring caesarian section ▪ Difficult labor ▪ Maternal death ▪ Fetal death

Source: WHO, 2000.

Although isolating the health impacts of trafficking itself (as opposed to the consequential conditions or experiences of trafficking) is challenging, purported health consequences of trafficking include: sexually transmitted infections, pelvic inflammatory disease, and HIV/AIDS, as a result of sexual exploitation; anxiety, insomnia, depression, and post-traumatic stress disorder; and diseases such as scabies, tuberculosis and other communicable diseases, as a result of unsanitary and crowded living conditions coupled with poor nutrition (U.S. Department of State, 2005).

ECONOMIC AND SOCIAL COSTS OF GENDER-BASED VIOLENCE

Gender-based violence has significant costs for the economies of developing countries in terms of lower worker productivity and incomes, lower rates of accumulation of human and social capital, and its strain on healthcare and judicial systems. Although studies measuring economic costs of GBV have not been conducted in the ECSA region, using the accounting method to estimate costs, the Center for Disease Control in the United States, estimated expenditures on medical and mental healthcare services for the 5.3 million incidents of domestic violence reported in 1995 to be US$5.1 billion (CDC, 2003 and Waters et al., 2004). Since services for GBV survivors are minimal to none or are often not solicited in developing countries, measuring indirect costs or the value of foregone earnings as a result of violence in both paid and unpaid work, may be more appropriate (Morrison and Orlando, 2005). Again data is limited, but in Nicaragua, for example, estimated indirect costs due to IPV were said to reduce GDP by 1.6 percent or US$32.7 million (WHO, 2004). This review did not uncover data on costs of sexual violence outside of intimate partnerships in developing countries. However, studies from the United States have found the cost of sexual violence to be anywhere from $85,000 per rape in both direct and indirect costs (Miller, Cohen, and Rossman in Krug et al., 2002) to $159 billion in direct, indirect, and non-monetary costs for more than 100,000 jury decisions (Cohen in Krug et al., 2002).

The social costs of gender-based violence, though not always as apparent as the health-related or economic costs, are just as grave. Indeed, social costs are also comprised of health-related and economic costs in that they are a detriment to society as a whole, not just the individual involved. For example, when children miss school, it is both a social and an economic cost in that it is a detriment to the long-term growth of society due to lost productivity in the long term. Moreover, declining health status may also be considered a social cost due to its implications regarding decreased productivity or participation in society. Furthermore, the experience of gender-based violence, regardless of the health status of the victim, can hinder the participation of women and children in the community and society simply due to the embarrassment, stigma, or mental and emotional distress that it can cause (Duvvury, Grown, and Redner, 2004).

Lastly, the effect of violence on children should also be recognized as a major social cost. The literature indicates that IPV and child abuse concur. When there is violence between the adult couple, the children are at risk for physical abuse (Browne and Hamilton, 1998; Hester, Pearson, and Harwin, 2000; Bowker, Arbitell, and McFerron, 1988; Giles-Sims, 1985; Guille, 2003; McCloskey, 1997; Tajima, 2000). Simply being exposed to violence, either direct or indirect, can have grave outcomes for children in complex and multi-dimensional ways. For instance, depression may result from lifetime exposure and post-traumatic stress disorder from recent exposure (Jaycox et al., 2002). Furthermore, children experiencing or even witnessing violence perpetuate violence in future generations and are at greater risk for becoming victims themselves (Duvurry, Grown, and Redner, 2004). This is known as the intergenerational or multiplier effect of violence. Overall, this effect results in a culture of violence in society that has major costs when considering the numbers mentioned above are multiplied.

IV. RISK FACTORS FOR GENDER-BASED VIOLENCE

INTIMATE PARTNER AND SEXUAL VIOLENCE

Definitions and Types of Risk Factors

The question "Why do men abuse women?" is a difficult one to answer. Unlike most other public health problems, the etiology of gender-based violence is quite complex due to the simple fact that it is a product of its societal context rather than biology (Jewkes, 2002). Thus, identifying the causes of gender-based violence has proved to be a never-ending challenge due to the fact there are so many potential contributing factors that are often difficult to measure, such as the level of the normative use of violence in the community or the effect of the women's lack of legal rights, which may exist but are not implemented. The body of literature, as experts would agree, is non-conclusive on what may be deemed as "causes" or determinants of gender-based violence. Rather, researchers have been able to identify factors that put men at greater risk for being abusive toward women or risk factors for gender-based violence.[9]

In the same vein, the question, "Why do men abuse women?" is difficult to answer because it can mean several things. As Armstrong neatly articulated it in her study on violence against women in Zimbabwe, the question "Why do men abuse women" can mean one of four things (Armstrong, 1998). First, it can mean "Why is *this* man abusive toward women?"—a question that seeks to understand the individual, psychological causes for abusive behavior. Second, it can mean "Why did the man abuse her at the time of the incident?"—a question that seeks to pinpoint the immediate cause for the violent episode or the situational risk factor. Or, it can mean, "Why do men in a particular setting abuse women [more than in other settings]?"—such as urban vs. rural Zimbabwe or the Northern Province vs. the Eastern Cape of South Africa. Finally, it can mean, "Why do *men* as a gender beat women?" These latter two questions explore the normative and socio-cultural risk factors for men's violence against women.

The Ecological Model

To better conceptualize these various risk factors, researchers have widely accepted the ecological model that comprises four levels that can each be matched to one of the four questions Armstrong iterates. These levels are (Heise, 1998; originally introduced in Garbarino and Crouter, 1978 and Bronfenbrenner, 1979, as cited in Krug et al., 2002):

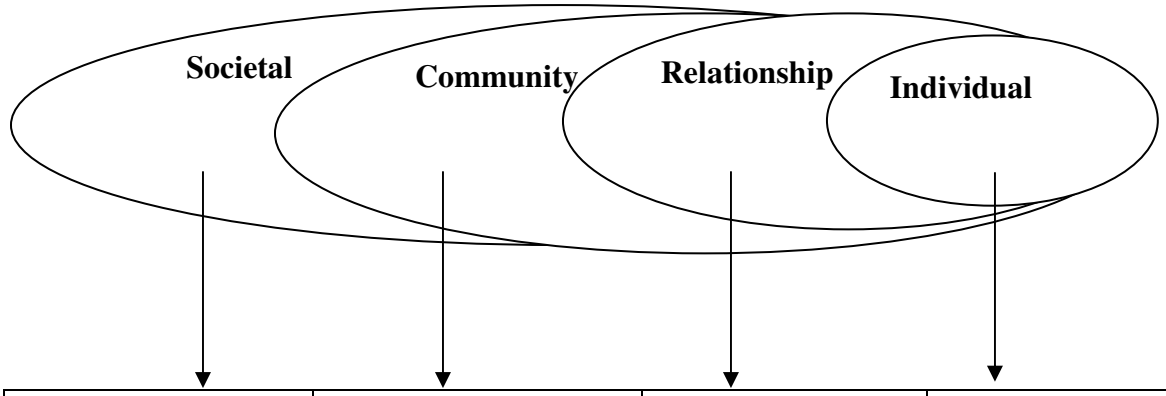
- **Individual level/personal**: Personal history factors that each individual bring to his or her behavior and relationships.
- **Relationship/situational**: The immediate context in which abuse takes place—frequently involving the family or other intimate or acquaintance relationships.
- **Community**: The institutions and social structures (both formal and informal) that are found in the immediate context of abuse, including the workplace, schools, neighborhood, social networks, and identity groups.
- **Societal**: The general views and attitudes in society and culture at large that make violence acceptable.

In trying to understand the risk factors pertaining to gender-based violence, Heise propounds that each of the above questions must be considered. That is, none of the explanations—individual,

[9] For more information on how the review was conducted and parameters for studies included in the report, please see Annex 1.

relationship, community-related, or societal—alone can explain why men abuse women. Understanding gender-based violence requires drawing on each of the types of explanations. This helps us understand the varying rates of abuse by men in the same society, state, or even province. Likewise, it helps explain why some men with particular behaviors, histories of abuse, or psychological dispositions are more apt to be abusive than others with similar personal characteristics (Heise, 1998). For example, cultures wherein masculinity is defined by aggression and women's status is low may still produce men who are not violent toward women. Many men in those cultures, however, may resort to physical abuse. When imposed with harsh enough sanctions, some of these men might reform their violent behavior; others still, likely those with a strong history of violence as a child, may never cease their tendency to be violent despite proper sanctions (Heise, 1998). Thus, central to the ecological model is that each level is overlapping as illustrated by Figure 3.

Figure 3. Risk factors associated with intimate partner and sexual violence: an ecological model



Societal	Community	Relationship	Individual
▪ Traditional gender norms that give men economic and decisionmaking power in the household ▪ Social norms that justify violence against women ▪ Social norms that restrict women's public visibility ▪ Women's lack of legal rights (including access to divorce) ▪ Lack of criminal sanctions against perpetrators of GBV (impunity) ▪ High levels of crime ▪ Armed conflict/post-conflict settings	▪ Weak community sanctions against GBV ▪ Lack of shelters or other forms of assistance/sanctuary ▪ Poverty ▪ Traditional gender roles for women in transition ▪ Normative use of violence to settle all types of dispute ▪ The safety of public spaces (as in refugee settings)	▪ Marital conflict ▪ Family dysfunction ▪ Male dominance in the family ▪ Economic stress ▪ Early age at marriage ▪ Large number of children ▪ Friction over women's empowerment ▪ Family honor considered more important than the health and safety of the victim ▪ Non-monogamous peers (including sexual partners)	▪ A history of violence in the perpetrator's or victim's family of origin (including intimate partner violence and child abuse) ▪ Male alcohol use ▪ Male personality disorders (particularly in low prevalence settings) ▪ Low income ▪ Young age (both women and men) ▪ Preference for impersonal sex

Adapted from Bott, Morrison, and Ellsberg, 2005; Krug et al., 2002; and Heise, 1998.

Rachel Jewkes and others have pointed out flaws in the ecological model, namely that (a) some risk factors could fit on multiple levels and (b) there are conceptual problems defining the difference between "community" and "society" (Jewkes, 2002). Several risk factors can indeed be placed in more than one of the levels. Poverty, for example, as studies show, can be an individual as well as a societal risk factor. Moreover, the fact that family honor is considered more important than the health and safety of the victim likely has its roots in society's preservation of traditional gender norms that undervalue women's individual rights. Likewise, many factors at the community and societal levels may be interchangeable (Jewkes, 2002). Nonetheless, it can be argued that these supposed flaws with the ecological model simply reflect the complex way in which risk factors related to gender-based violence interact. More importantly, despite these concerns about the ecological model, Jewkes also notes that it continues to have value for the purposes of advocacy and identifying promising interventions, which are ultimately the purpose of this review.

A Summary of Risk Factors

Individual Risk Factors

Studies found that as a man's *educational status* increases, his likelihood for physically assaulting a partner decreases. In Nairobi, Kenya, husbands with a lower primary educational level and those with no education made up the majority of perpetrators (FIDA Kenya, 2002). In South Africa, men who had not received post-school training and illiterate men, respectively, were three times more likely to report perpetrating sexual abuse than those who had such training (Abrahams et al., 2004; Araya, 2001). Nonetheless, the studies neglected to look at whether this likelihood to report was truly a willingness to report. In other words, openness in reporting may merely be a byproduct of lack of education, which is said to cause individuals to place a lower stigma on violence, thereby increasing one's willingness to disclose.

The relationship between women's *educational status* and experiencing violence poses similar challenges. In Uganda and South Africa, women with higher levels of education—secondary school or higher—appear to be at lower risks for violence than less educated women (Koenig et al., 2003; Jewkes; Levin and Penn-Kekana, 2002), though the study from Uganda found the relationship to be curvilinear, with violence lowest for women with no education and for women with eight or more years of education. In Kenya, however, women with secondary school education reported more violence compared with women with no education or those with only primary education (FIDA Kenya, 2002).

Numerous studies found that *alcohol use by men* is also consistently positively correlated with women's experience of intimate partner violence, both physical and sexual (Araya, 2001; Abrahams et al., 2004). In fact, some research has shown that men use alcohol as an aid for their violent actions; findings suggest that some men feel less accountable for their violent actions when drunk and others intentionally use alcohol to enable them to beat their wives, which they feel is socially expected of them (Jewkes, 2002). The notion that alcohol itself causes violence against women is rather controversial (Gelles, 1993). It is more likely that alcohol reduces inhibitions, clouds judgment, and impairs abilities to interpret social cues, thereby making some men who are more predisposed to violent behavior more likely to engage in violence, including violence against women (Jewkes, 2002). Focus groups and interviews in Uganda, for example, identified alcohol as a "trigger" for intimate partner violence (Okot, Amony, and Otim, 2005). Additionally, both quantitative and qualitative studies in Kenya, South Africa, Rwanda, Uganda, and Zimbabwe found that women who experienced violence were also much more likely to report that their partners drink alcohol (Armostrong, 1998; Becker, 2003; FIDA Kenya, 2002; Ministry of Gender and Family Promotion, Republic of Rwanda, 2004; Koenig et al., 2003; Jewkes, Levin, and Penn-Kekana, 2002; Abrahams et al., 2004; Watts, Ndlovu, and Kwaramba, 1998; Rusakaniko, Mushunje, and Muchumenye, 1997).

Moreover, studies in South Africa suggest that *alcohol use by women* themselves increases their risk for victimization (Jewkes and Penn-Kekana, 2002; Kalichman and Simbayi, 2004; Dunkle, 2004). It is important to note, however, that women's consumption of alcohol may in fact be a result of and not a precipitating factor for violence they suffer at the hands of their intimate partners (Heise, Ellsberg, and Gottoemeller, 1999). But the lack of longitudinal studies in the review makes the direction of the relationship between women's alcohol consumption and their exposure to violence inconclusive.

Young age of women is a risk factor for experiencing sexual violence both in and outside of intimate partnerships, but the evidence is inconclusive with respect to physical IPV. In Uganda, for example, Koenig and colleagues determined that young age is a risk factor for experiencing sexual coercion but not for physical violence in general (Koenig et al., 2004). Some research suggests that this increased risk of sexual coercion may be related to women's inexperience or the lack of a support system at a young age. For example, a qualitative study in Botswana observed young age as a risk factor for violence, but the authors associated this primarily to the fact that older women had what Counts, Brown, and Campbell call sanctuary or places of refuge to which they could escape from their violent partners (Draper in Counts, Brown, and Campbell, 1999). Moreover, while most international research has shown that the age of either partner is not significantly associated with violence against women (Jewkes, 2002), studies in the United States have shown a man's young age to consistently be linked to his likelihood to commit physical violence against a partner (Krug, et. al, 2002).

A *history of violence in the victim or perpetrator's family* has been consistently and highly correlated to both carrying out and experiencing intimate partner violence, both physical and sexual. This underscores the fact that violence is at least in part a learned behavior (Krug et al., 2002). Studies in South Africa and Ethiopia reflect the same. In South Africa, men who receive frequent beatings and who witness their mother being abused during childhood are significantly more likely to be sexually violent toward their partners (Abrahams et al., 2004). Women's experience of violence as a child, either being beaten or their mothers being beaten—is also positively associated with women's experience of domestic violence (Jewkes, Levin, and Penn-Kekana, 2002). In Ethiopia, although findings are still preliminary, women who had experienced physical or sexual partner violence were more likely to report that their husband's mothers were abused (Gossaye et al., 2003). Likewise, women in Ethiopia who had experienced physical or sexual partner violence were also more likely to report that their own mothers had been abused (Gossaye et al., 2003).

Relationship Risk Factors

Early marriage is a risk factor for experiencing both intimate partner and sexual violence. In Zambia, the risk of violence declines as age at first marriage increases (Kishor and Johnson, 2004). A study in Kenya found that among young women ages 15–24, those who had ever been married were much more likely to have experienced sexual coercion (Erulkar, 2004). In a similar sense, early marriage, which is discussed in further detail below, is also considered a risk factor for gender-based violence. In short, researchers argue that the large age disparity that typically characterizes early marriage, often ten years or more, between girls and their husbands, aggravates the relationship of power and control of a husband over his wife. As a result, girls with much older husbands are at greater risk for forced sex and physical violence than are women in relationships with age symmetry (see Silberschmidt and Rasch, 2001).

In Kenya, Rwanda, South Africa, and Zimbabwe, quantitative studies found that *friction over women's empowerment* is an important risk factor for women's experience of violence at the hands of their partners (FIDA Kenya, 2002; Ministry of Gender and Family Promotion, Republic of Rwanda, 2004; Jewkes, Levin, and Penn-Kekana, 2002; Watts, Ndlovu, and Kwaramba, 1998). In Kenya, Rwanda, and Zimbabwe, respectively, women who were in professional occupations, who had paid employment

and husbands with lesser education than themselves and those that had their own income were at greater risk for violence by their partners. The findings from South Africa show that liberal ideas on women's roles also increase risk for violence. That is, "abused women were less likely to say that they believed that woman should obey her husband, give him her money, get his permission before working, that he should have the final say in family matters, and that he can punish her"(Jewkes, Levin, and Penn-Kekana, 2002). In Uganda, qualitative research also found a similar pattern, where friction over women's empowerment was said to be a trigger for IPV (Okot, Amony, and Otim, 2005).

Studies outside Africa have found that women's empowerment or financial independence can protect women from violence by their partners, namely in settings where women have a better status in the community (Koenig et al., 2003). However, in societies in transition, where women's rights and participation in public life are increasing but traditional norms are still prevalent, as in ECSA, preliminary findings discussed above point to the fact that women face increased risks of violence. As with education, growing empowerment may cause men to fear loss of control and to feel their masculinity challenged, thereby reacting with violence against their partners. As the report shall later elaborate upon, cultural norms in countries across ECSA, such as Eritrea, South Africa, Tanzania, Uganda, and Zimbabwe, are such that men feel challenged by the economic and social empowerment of their partners. Increasing empowerment may be needed for women to truly escape the cycle of violence.

Closely related to friction over women's empowerment is *economic stress* resulting from a lack of productive work. In ECSA, evidence suggests that economic stress may be a risk factor for intimate partner violence. In Zimbabwe, financial problems were measured as a risk factor for domestic violence (Rusakaniko, Mushunje, and Muchumenye, 1997). Likewise, qualitative studies in Uganda and South Africa determined that as men became more idle, frustrations over their inability to live up to masculine ideals of being the provider cause them to be violent toward their partners (Okot, Amony, and Otim, 2005; Becker, 2003). Overall, these findings are not conclusive; however, research outside the region has shown that stress, including economic stress, is not a key contributor to intimate partner violence (Jewkes, 2002).

Also in line with friction over women's empowerment is *male dominance in the family or relationship*, as the friction results precisely from the notion that men have the last word in the household. Thus, the above findings on friction over women's empowerment could also support the argument that male dominance in the family is a risk factor. However, we include under male dominance, findings wherein women did not specifically claim to challenge male dominance but nonetheless were subject to it. In South Africa, for example, researchers determined that women currently in relationships with high levels of male control were more likely to report recent and previous partner violence (Dunkle, 2004). In Rwanda, women who reported partner insistence on sex were significantly more likely to be beaten by their partners (Van der Straten et al., 1998). Other qualitative studies in Rwanda, South Africa, and Zimbabwe noted that men use violence as a way to impose superiority and control, specifically with respect to money, household chores, reproductive and childcare issues, his or her infidelity, and perhaps most commonly, when to have sex (Ministry of Gender and Family Promotion, Republic of Rwanda, 2004; Becker, 2003; Wood and Jewkes, 1998; Armstrong, 1998). Male dominance may also come with a considerable age gap between a female and her partner (her partner being much older). This was found in Kenya where young women ages 15–24 with partners five or more years older had experienced more sexual coercion compared with other young women in the same age group (Erulkar, 2004).

As would be expected, *marital conflict,* which again can be related to male dominance in the family, is a major risk factor for intimate partner violence. In South Africa, women with frequent general conflict in their relationships were nearly 17 times as likely to experience violence in the past year (Jewkes, Levin, and Penn-Kekana, 2002). In Kenya, women who were divorced or separated—presumably as a result of marital conflict—were more than four times as likely to have experienced

sexual coercion (Erulkar, 2004). This data does not allow us to establish whether marital conflict precedes domestic violence or comes as a result of it, which may be the case when women who experience domestic violence come to respect their partners less (Jewkes and Penn-Kekana, 2002). Qualitative studies point to the former, however. In Kenya, women cited conflict over money as the leading cause for intimate partner violence (FIDA Kenya, 2002). A qualitative study in Zimbabwe involving one hundred women also found that most events that instigated violence by partners were arguments, whether they are over money, another woman, or relatives (Armstrong, 1998).

Intimate partner violence, including sexual and physical violence, is also correlated to involvement with *non-monogamous sexual partners*. Tanzanian and South African women whose partners had another sex partner were approximately five times more likely to experience violence ever and in the past year than women whose partners were monogamous (Maman, 2001; Jewkes, Levin, and Penn-Kekana, 2002). In Zimbabwe, women who knew that their partners had girlfriends were also much more likely to experience forced sex (Watts, Ndlovu, and Kwaramba, 1998). Research findings from Rwanda and South Africa indicate that men retaliate with violence when their fidelity is questioned (Ministry of Gender and Family Promotion, Republic of Rwanda, 2004; Wood and Jewkes, 1998).

Community Risk Factors

Categorizing *poverty* under any one of the levels of the ecological model is a challenging task. Whereas the model classifies it as a community-level factor, and in keeping with that, we discuss it here; evidence points to the fact that poverty may also be considered an individual, relationship, or societal factor. In settings as diverse as the United States, Nicaragua, and India, violence is more frequent in lower socioeconomic groups, pointing to poverty's importance as a community and societal risk factor (Jewkes, 2002). Several qualitative studies in the ECSA region also cited poverty in general as a "cause" for intimate partner violence (see Okot, Amony, and Otim, 2005). Furthermore, as discussed above, economic stress—considered a relationship factor—may also contribute to levels of violence.

Most studies in ECSA, however, show that it is likely more relevant to discuss poverty as an individual risk factor. On the one hand, some evidence suggests that household poverty does not seem to be a risk factor for intimate partner violence. In fact, studies in Rwanda and South Africa found that women in some of the poorest households, particularly those that are supported by someone other than the woman or her partner, are protected from intimate partner violence (Ministry of Gender and Family Promotion, Republic of Rwanda; 2004, Jewkes, Levin, and Penn-Kekana, 2002). Possible reasons for this protection are that women in poorer households may not be challenging male dominance (Jewkes, 2002) and that these couples are dependent on an outside source for income, thereby minimizing economic stress (Ministry of Gender and Family Promotion, Republic of Rwanda). On the other hand, women's financial dependence on men was often found to be an explanation or excuse for intimate partner violence as well as sexual violence outside of partnerships. Invoking the "sanctions and sanctuary" theory, Draper argues that women of higher economic status in Botswana had more family and friends to rely on to provide sanctuary and, thus, were protected against violence (Draper in Counts, Brown, and Campbell, 1999).

Worldwide, including in ECSA, *weak community sanctions against* intimate partner violence appear to contribute to the prevalence of violence against women in particular settings. Evidence suggests that in settings where family and community do not tolerate wife abuse, incidences of it are low (Counts, Brown, and Campbell, 1999). Conversely, communities that support violence are also said to have more violence against women. In Zimbabwe, for example, peer influence is a significant fact that increases levels of domestic violence (Rusakaniko et al., 1997).

Various situational analyses by Amnesty International, the International Rescue Committee, and Human Rights Watch (see Amnesty International, 2004b, Human Rights Watch, 2005; Okot, Amony, and Otim, 2005; Mabuwa, 2000; and UNICEF et al., 2004) cited the *lack of safety in public spaces* as a risk for gender-based violence in refugee settings. More specifically, the physical setup of refugee camps, including their poor lighting and the need for women to go in search of firewood and other resources for survival, make women vulnerable to sexual violence. Refugee camps are a unique community in that they are makeshift in nature and lack much infrastructure. As such, they *lack shelters and other forms of assistance or sanctuary* for GBV survivors as well as criminal sanctions against GBV (Mabuwa, 2000; Ward, 2002). In resource-poor Africa, however, this is also true of other countries in the region, though not explicitly identified in all studies as a risk factor.

Societal Risk Factors

Much like community sanctions, *criminal sanctions* theoretically help mitigate levels of violence against women. Nonetheless, with very weak laws and criminal sanctions in place, measuring the impact of criminal sanctions on levels of violence proves challenging. Various reports, (see Center for Reproductive Law and Policy, 2001; Chuulu, 2001; Eltigani and Khaled, 1999; and Ballard-Reisch et al., 2001) as discussed later in this review, emphasized gaps in the legal systems throughout the region that are particularly problematic for the prevention of gender-based violence. Such gaps include and range from a complete lack of laws that sanction violence against women specifically, police that often turn their eye or are complicit with perpetrators, a culture that promotes reconciliation rather than due justice, lenient punishments for convicted perpetrators, and the failure to criminalize marital rape.

Strong evidence suggests that at the societal level, *normative use of violence to settle disputes* is a risk factor for higher levels of gender-based violence. In Ethiopia, women who were victims of physical or sexual partner violence were more likely than non-victims to report that their husbands fought with other men; while in South Africa, physical violence outside the home is significantly associated with the perpetration of sexual violence (Gossaye et al., 2003, Abrahams et al., 2004). Qualitative studies in South Africa confirm these findings; boys and girls alike attested that violence is used to gain control and impose punishments in a variety of contexts, including husbands against wives, parents against children, and teachers against pupils (Wood and Jewkes, 1998; Wood and Jewkes, 2001).

Time and again, studies pointed to *social norms,* including *traditional gender norms,* as root causes or risk factors for the occurrence of violence against women. Emerging literature has discussed violence perpetrated by men not only against women but also against men as a way to assert their masculinity, which is defined largely by being strong and aggressive. As Barker and Ricardo (2005) put it, "…many of the problematic behaviors of young men—for example, the use of sexual coercion and violence against women, unsafe sexual behavior, and participation in violence or local insurgencies—are often efforts by young men to publicly define or affirm themselves as men."

Most studies supporting this argument are qualitative but, nonetheless, persuasive. In Namibia and South Africa's Eastern Cape, various members of society, including parents, community men and women, police, social workers, health workers, NGO staff, and teachers, held girls who were victims of rape accountable for their victimization (Jewkes, Penn-Kekana and Rose-Junius, 2005). Meanwhile, the perpetrators were excused for behaving "like men do in such situations," namely that women made themselves vulnerable by being in the wrong place or somehow encouraging men's sexual advances (Jewkes, Penn-Kekana, and Rose-Junius, 2005). Studies in South Africa also found that wife abuse is also widely accepted in some cases to the point that it was perceived as an expression of love (Wood and Jewkes, 1998; Wood and Jewkes, 2001) or justified if women were "cheeky" (Becker, 2003). In Rwanda, 84 percent of women thought that illness was a reason for refusing sexual relations, but only 26 percent thought a lack of desire was a good enough reason. Overall, most women saw obedience as way to

prevent violence (Ministry of Gender and Family Promotion, Republic of Rwanda, 2004). In Eritrea, Tanzania, Uganda, and Zimbabwe, where many women accept violence if they do not do their chores, refuse sex, and are generally socialized to accept their subordination to men, the same culture pervades (DHS in IGWG, 2002; Lary et al., 2004, Okot, Amony, and Otim, 2005; Leach, Machakanja, and Mandoga, 2000).

Box 3. Gender-Based Violence Experienced by Men

Traditional gender norms also fuel much violence experienced by men. Although an in-depth review of risk factors and interventions related to GBV against men is beyond the scope of this report, this type of violence should also be recognized as a form of gender-based violence. According to the World Health Organization, "Rape and other forms of sexual coercion directed against men and boys take place in a variety of settings, including in the home, the workplace, schools, on the streets, in the military and during war, as well as in prisons and police custody" (Krug et al., 2002). Men that do not live up to standard notions of masculinity may be particularly subject to this type of violence. For example, men who have sex with men and who live a visible lifestyle as homosexuals have suffered violence and social ostracism. More specifically, in Kenya, nearly 40 percent of men who had sex with men reported having been raped outside their home and 13 percent report having been assaulted by the police (Niang et al. 2002 in Barker and Ricardo, 2005).

While GBV against men is a significant problem, it is one that has hardly been researched both in ECSA and worldwide. Among the few population-based studies conducted with adolescents in developing countries, 13.4 percent of males in the United Republic of Tanzania reported to have been victims of sexual assault (Krug et al., 2002). In the baseline study for Stepping Stones evaluation in the Eastern Cape of South Africa, almost 3 percent of men reported having been coerced into sex by a man and 12 percent reported being coerced by a woman (Sikweiyiya et al., forthcoming). These figures and other data, as most experts believe, is likely an under-representation of male rape victims, as males are even less likely than females to report their experience of sexual assault due to prejudices regarding male sexuality that compound guilt, fear, and shame (Krug et al., 2002). Understanding the true nature of GBV experienced by men and how to address it will require much more research than currently exists.

Bride price, another manifestation of traditional gender norms that is practiced in some parts of ECSA, may also contribute to violence against women. Qualitative research findings suggest that it supports the belief that women are the property of their families and, later, their husbands; and that husbands who pay bride price are then entitled to beat their wives (Bourke-Martignoni, 2002; Kim and Motsei, 2002; Ward, 2005). Interviews with high school students in Zimbabwe and Lesotho reported mixed feelings toward bride price. While supporting the cultural significance of the practice, they recognized the ways in which it serves men and women differently. Girls acknowledged that bride price makes it difficult for woman to escape a marriage, even in situations of violence and mistreatment. Boys agreed that having paid bride price entitled a man to beat his wife if she had sex with another man (and also reported that had they not paid bride price, they would simply divorce their wives in this situation) (Ansell, 2001).

Other behaviors associated with traditional gender norms include wife inheritance and the preference of a boy child. Wife inheritance[10] was seen by women surveyed in South Africa and Uganda as

[10] In wife inheritance, a male relative of the dead husband typically takes over the widow as a wife, often junior to other wives. Many consider wife inheritance a form of violence in and of itself in that it is a type of forced marriage. The body of research in that respect, however, is still quite limited.

factors that contribute to violence against women (Dangor, Hoff and Scott, 1998; Okot, Amony, and Otim, 2005). In Ethiopia, Kenya, and South Africa, studies have found that intimate partner violence is also highly associated with the preference for a boy child by women's partners (Gossaye et al., 2003; Jewkes, Levin, and Penn-Kekana, 2002; Erulkar, 2003).

Reinforcing the above findings, a cross-cultural study conducted by Levinson has shown that societies wherein there is greater sexual inequality, intimate partner violence is greater. Levinson found the following variables defining sexual inequality to be significant: men control the fruits of family labor; men have the final say in domestic decision-making; divorce is more difficult for women than for men; women do not band together in exclusively female work groups; and the husband's kin group controls his widow's right to remarry have a higher prevalence of wife-beating (Levinson, 1989).

Sexual Violence and Sexual Coercion

Most of the above risk factors for intimate partner violence are also risk factors for sexual violence and sexual coercion. In fact, as previously discussed, women's intimate partners perpetrate many, if not most, cases of sexual violence. In particular, alcohol and drug use, a history of abuse by both victim and perpetrator, weak sanctions against sexual violence, and patriarchal norms that condone such abuse all hold as risk factors for sexual violence and coercion. There are, however, risk factors particular to the context of sexual violence and coercion outside of intimate partnerships, which should be recognized.

Poverty appears to put women at greater risk of sexual violence outside of intimate partnerships just as it does within. However, they are quite distinct manifestations of poverty that increase risk. In particular, recent studies have found that women's engagement in *transactional sex*[11] may put them at special risk for experiencing sexual violence. In South Africa, transactional sex has a statistical association with forced first intercourse: those who engaged in forced fist sex were more likely to have engaged in transactional sex (Dunkle, 2004). Additionally, sexual violence is more socially accepted in situations where women received money from the perpetrator in exchange for sex. As one South African interviewee put it, "If you can feed a horse, you can ride it" (Wojcicki, 2002). Whether transactional sex increases risk of forced sex or the reverse, however, is not clear, as women who are sexually assaulted are also more likely to exchange sex to meet survival needs than those who had not been sexually assaulted (Kalichman and Simbayi, 2004; Dunkle, 2004).

In a similar way as transactional sex, researchers suggest that the *sugar-daddy effect* may exacerbate relations of male dominance and, thus, intimate partner violence (Luke and Kurz, 2002; Luke, 2004; Kaufman and Stavrou, 2002; Leach, Machakanja, and Mandoga, 2000). Some researchers argue that the sugar-daddy effect is at least in part a byproduct of poverty, as girls accept money and gifts for the purpose of economic gain for themselves and their families (Luke, 2004; Leach, Machakanja, and Mandoga, 2000). Research across sub-Saharan Africa has found that girls seek relationships with older men because they are perceived as more marriageable: older men are said to be more economically secure, serious about marriage, and more likely to marry or support a girl if she becomes pregnant unintentionally (Luke and Kurz, 2002). Meanwhile, men promise love, marriage, or gifts in order to engage young girls and women sexually, use them as domestic help, or maintain health as young females are seen as less likely to be infected with HIV (Luke and Kurz, 2004). It is important to recognize, however, that a girl does not have to be poor to be lured by gifts.

[11] Transactional sex may be defined as the use of sex as a commodity in exchange for goods, services, money, accommodation, or other basic necessities. Transactional sex involves non-marital sexual relationships, often with multiple and older male partners (UNFPA, http://www.unfpa.org/gender/aids1.htm).

While weak community sanctions against both intimate partner and sexual violence has been mentioned above as causes for the occurrences of these abuses, evidence worldwide and alarmingly so in Africa, demonstrates that a particular community puts girls at risk for sexual violence and coercion: the school community. In Uganda, South Africa, and Zimbabwe, and likely in other countries in the region, school communities perpetuate the acceptance of violence against women. In-depth qualitative studies, including interviews with students and teachers in a range of school settings in these countries found that female students often suffer rape, sexual touching, and other forms of sexual abuse by both fellow students and male teachers. Yet, school authorities, accepting the incidences as part of the local culture, almost always turn a blind eye (Human Rights Watch, 2001; Mirembe and Davies, 2001; Leach, Machakanja,and Mandoga, 2000; Mirsky, 2003). In South Africa, a survey found that teachers perpetrated 32 percent of rapes experienced by women 15 years or younger. (Krug et al., 2002).

Why Men Abuse Women: An Issue of Gender

In conclusion, we return again to the question "Why do men abuse women?" Leading researchers in the region argue that the two essential factors underlying intimate partner violence are the subordinate status of women and the general acceptance of interpersonal violence in society, relegating the other factors detailed above as associated or mitigating factors (Jewkes, Levin, and Penn-Kekanana, 2002). Women's low education or economic status, they argue, are correlated to their unequal status in society, which when challenged, cause men to react with violence against women. The vicious cycle is hard to break; however, as even with some economic independence, which is rare in ECSA societies, socio-cultural norms and laws make it difficult for women to leave their violent partners. Challenging this unequal status can be even more difficult at a young age. Moreover, the conflict over resources that comes as a result of poverty may be mediated through violence where violence is the norm. In turn, where violence against women is normative, sanctions against violent men, both social and legal, are usually low. Finally, alcohol acts at times as a trigger for violence by increasing the likelihood for conflict and reducing inhibitions. Overall, the preceding review of risk factors for IPV in the ECSA region appears to support this thesis.

EARLY MARRIAGE

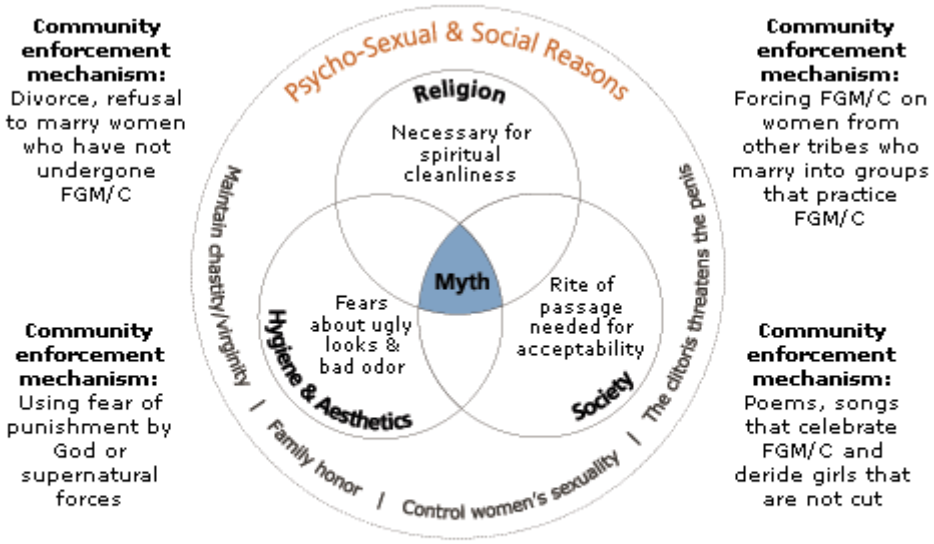
Though there have been no empirical studies on risk factors for early marriage, literature on early marriage has shown correlations between the practice and poverty, women's educational level, and bride price. Early marriage is most prevalent in the poorest 20 percent of the world's population (UNICEF, 2005). In some poor areas, girls are seen as economic burdens in the family, and, thus, marriage is sometimes seen as an economic arrangement and a means to protect daughters from unwanted sex and risk of premarital pregnancy (Murphy and Hendrix-Jenkins, 2002). Similarly, evidence suggests that bride price, "the provision of gifts to the parents of a bride, usually in the form of cash or livestock" (Ansell, 2001) may increase the social and economic pressure of parents to marry their daughters early and without their consent (especially among those living in poverty). Finally, analysis of DHS data shows that as girls' education levels increase, the likelihood of marrying early decreases. (UNICEF, 2005; Singh and Samara, 1996). For example, in Tanzania, women with a secondary education were 92 percent less likely to be married by the age of 18 than those women who had primary education only (UNICEF, 2001); in the Amhara region of Ethiopia, 83 percent of ever-married girls had never attended school, compared with 35 percent of never-married girls (Erulkar et al., 2004).

FEMALE GENITAL CUTTING

FGC/M is practiced at all educational and social levels and across varying religions (PRB, 2005). It is a deeply embedded cultural practice and, thus, understanding the factors that sustain FGC/M requires understanding the culture, norms, and beliefs that have supported it through time. The WHO (1999)

argues that there are three overlapping reasons for the practice—spiritual and religious reasons, sociological reasons, and hygienic and aesthetic reasons (see Figure 4). Religion dictates the removal of the clitoris and external genitalia because they are said to make women spiritually unclean. The clitoris is also believed to prevent women from reaching maturity and having the right to identify with a persons age group, the ancestors, and the human race (WHO, 1999). In that vein, women feel that it is their duty to cut their daughters or else they will not be prepared for adulthood and marriage (Lewnes, A. (ed.)/UNICEF Innocenti Research Centre, 2005). If not circumcised, girls are likely to face stigma, social isolation, and difficulty in finding a husband. According to the numerous myths associated with this set of beliefs, the external genitalia have the power to make a birth attendant blind; cause infants to become abnormal, insane, or die; or cause husbands and fathers to die (WHO, 1999). Finally, the clitoris and genitalia are also believed to be ugly and dirty, and if not excised, can grow to unsightly proportions (WHO, 1999).

Figure 4. Why female genital cutting continues: a mental map (PRB, 2005)



Source: adapted from: Asha Mohamud, Nancy Ali, Nancy Yinger, World Health Organization and Program for Appropriate Technology in Health (WHO/PATH), FGM Programs to Date: What Works and What Doesn't (Geneva: WHO, 1999): 7.

Encompassing the above three overlapping reasons are psycho-sexual perceptions that support FGC/M. In particular, a young woman's sexuality has to be controlled to ensure that she does not become over-sexed and lose her virginity, thereby disgracing her family and losing her chance for marriage. An "uncut" clitoris is believed to cause a woman to become promiscuous by growing so big that the woman will not be able to control her sexual desires. As such, an "uncut" clitoris is perceived as a threat to the entire community (WHO, 1999).

The above reasons influence and support FGC/M to varying degrees in different countries and communities. As the WHO (1999) offered, "Muslim countries tend to associate the practice with tradition as well as with Islam; some communities emphasize the rite of passage from childhood to adulthood (Burkina Faso, Ethiopia, Kenya, and Sierra Leone) or to humanity (some Eritreans); and others emphasize the mythological aspects (e.g., in Nigeria some people believe that if the head of the baby touches the clitoris, the baby will die)."

HUMAN TRAFFICKING

Women and girls are said to be at increased risk for trafficking for a number of reasons. On the demand side, UNIFEM/UNIAP provides the following factors:

- *women's perceived suitability* for work in labor-intensive production and the growing informal sector, which is characterized by low wages, casual employment, hazardous work conditions, and the absence of collective bargaining mechanisms;
- the *increasing demand for foreign workers* for domestic and care-giving roles and a lack of adequate regulatory frameworks to support this;
- the *growth of the billion-dollar sex and entertainment industry*, tolerated as a "necessary evil," while women in prostitution are criminalized and discriminated against;
- the *low risk-high profit nature* of trafficking encouraged by a lack of will on the part of enforcement agencies to prosecute traffickers (which includes owners/managers of institutions into which persons are trafficked);
- the *ease in controlling* and manipulating vulnerable women;
- the *lack of access to legal redress* or remedies for victims of traffickers; and
- the *devaluation of women and children's human rights* (UNIFEM/UNIAP, 2002).

On the supply side, the following factors put women and girls at greater risk:

- *unequal access to education* that limits women's opportunities to increase their
- earnings in more skilled occupations;
- the *lack of legitimate and fulfilling employment opportunities* particularly in rural communities;
- *sex-selective migration policies* and restrictive emigration policies/laws, instituted often as "protective" measures, limit women's legitimate migration. Most legal channels of migration offer opportunities in typically male-dominated sectors (construction and agriculture work);
- *less access to information* on migration/job opportunities and recruitment channels;
- the *lack of awareness* of the risks of migration compared with men;
- the *disruption of support systems* due to natural and human created catastrophes; and
- *traditional community attitudes* and practices, which tolerate violence against women (UNIFEM/UNIAP, 2002).

Research specific to Africa indicates that poverty is a major reason that women and children fall prey to trafficking (IOM, 2005). Adepoju's recent review of the literature finds that "Unemployment, low wages, and poor living standards drive some desperate women into the hands of traffickers…Poor women who wish to migrate to rich countries may simply be looking for better job opportunities in order to assist their families. In the process, some fall prey to traffickers. Though some of the trafficked women are willing to participate in prostitution in order to escape the poverty trap, deception is the most common strategy used in procuring them and young girls under the guise of offers for further education, marriage, and remunerative jobs" (IOM, 2005). Adding to hopelessness of poverty that makes Africa, particularly Southern Africa, ripe for trafficking are the porous borders and civil and political unrest that have made a free flow of both documented and undocumented migrants the norm in the region (IOM, 2003).

V. PROMISING INTERVENTIONS TO ADDRESS GENDER-BASED VIOLENCE

BACKGROUND

Although this review identified numerous initiatives both to respond to as well as prevent gender-based violence in ECSA, few interventions were rigorously evaluated to determine the impact of the programs. This problem is not unique to Africa, but is a worldwide phenomenon (Krug et. al, 2002). It is especially true that where resources are few, investing in evaluation is often seen as a luxury. Of those interventions that were evaluated at all, most relied on qualitative evaluations involving focus group discussions or key informant interviews with service providers and stakeholders. Other weaknesses in the evaluations include:

- a reliance on process or output indicators (e.g., measuring the number of people reached or activities carried out), rather than indicators that measure long-term impact on participants' lives;
- small sample sizes due to the limited scale of interventions;
- a lack of baseline data;
- a lack of control groups;
- limited or no follow-up to determine longer term impact on the behavior of participants; and
- a focus on the impact on prevention, while providing little analysis of the impact on care.

Given these limitations, the following review discusses "promising" interventions to the extent that they were qualitatively, if not quantitatively, evaluated at the least through an assessment of good practices and lessons learned. Moreover, given that there are several promising interventions outside the region that have simply not been applied in ECSA, perhaps due to a scarcity in political will and resources, this review also relies heavily on recent global reviews to discuss those interventions where appropriate. The conceptual framework discussed in the next section, however, will allow us to see the gaps in programming in the region.

Lastly, as most of the evaluations, or more appropriately, assessments, looked at the impact of programs on prevention, this review will focus largely on interventions to prevent gender-based violence. Thus, it is important to note the challenges in evaluating the impact of prevention interventions. First, multisectoral and multistrategy approaches, often necessary when addressing GBV, make it difficult to determine the precise intervention that caused positive change (Bott, Morrison, and Ellsberg, 2005). Secondly, while defining and measuring initial levels of violence itself is problematic, as described above, measuring changes in the levels of violence is even more complicated. Successful programs may appear to increase levels of violence as greater sensitization may cause women and girls simply to be more willing to report violence rather than prevalence actually changing (Bott, Morrison, and Ellsberg, 2005). Or, some programs that empower women may indeed increase conflict in relationships, and therefore, violence against women in the short term (Koenig et al., 2003). Yet few programs do follow-up evaluations to determine changing levels of violence in the long term.

Conceptual Framework and Organization

To compile this review, interventions were sorted by sector and/or target population and then by the type of intervention. Sectors and/or target populations include health, justice/legal/security, education/youth, and refugee populations. These categories are combined and adapted from conceptual frameworks of two recent global reviews of promising interventions related to GBV: Bott, Morrison, and Ellsberg, 2005; and Guedes, 2004. Classifications for interventions (also drawn from Bott, Morrison, and Ellsberg, 2005; and Bott and Betron, unpublished) are:

- **Laws and Policies**—drafting legislation, advocating for legislative and policy changes, and educating policymakers, including parliamentarians.
- **Institutional reform—**training of staff or volunteers, expanding services, improving the quality of services and strengthening institutional policies and protocols, referral networks among institutions serving GBV survivors.
- **Community mobilization**—raising overall community awareness, mobilizing community-based efforts, and mass media campaigns.
- **Individual behavior changes—**improving knowledge, attitudes, and practices of community members.

These types of interventions may also be seen as pertaining to each level in the ecological model, when laws, policy, and advocacy pertain to the societal level; institutional reforms apply to both the societal and community levels; community mobilization corresponds to the community level; and individual behavior change strategies address relationship and individual levels.

It should also be pointed out here that community mobilization and individual behavior change interventions often, but not always, go hand in hand. Thus, several programs may be categorized as one, the other, or both. When programs address individual as well as community-wide behavior change through the use of public venues or media, we categorize them under community mobilization. Programs that target just specific individuals or groups are classified under individual behavior change interventions. The important thing to recognize, however, is that community mobilization and individual behavior change indeed should go hand in hand in order to produce lasting results, as we shall later elaborate upon (Rogers 1995; CDC, 2004).

As mentioned, the review found that not all levels of interventions in each sector are addressed in ECSA, but the framework allows us to identify gaps. On the other hand, although interventions are presented under individual sectors and/or levels of interventions, several programs address more than one sector. Such programs are addressed in each relevant sector. However, holistic multisectoral programs, that is, programs that span all sectors, are discussed in the special section on multisectoral programs. A multisectoral approach, as shall be later emphasized, is in fact central to preventing gender-based violence. In the meantime, however, we shall look at interventions according to their sector and level for ease of organization.

Health

The health sector is an important entry-point for addressing gender-based violence not only as a means for treating victims, but also for prevention. Statistics have shown that most women do not report cases of intimate partner violence (see Kishor and Johnson, 2004) due to stigma or shame, but often do present to health professionals injuries resulting from it, without explicitly indicating themselves as victims of intimate partner violence (Velzeboer et al., 2003). Thus, if adequately trained and equipped, health providers can detect cases of intimate partner violence and begin the process not only of healing but also change. The health sector, through outreach and education, can, as this section will show, play a key role in changing attitudes and behavior related to gender and sexual and reproductive health.

Laws and policies relating to GBV in the health sector include those regarding the health sector's role in legal reporting and prosecuting of cases, including protocols to fulfill that role. Attempts to change *laws and policies* in the health sector have been few in the ECSA region. Documented attempts assessing effectiveness of such laws and policies are even fewer, though there a few notable exceptions. In Rwanda, the International Rescue Committee and local nongovernmental organizations worked with the Ministry of Health to provide officials with technical assistance on how to respond to GBV, but obtaining their participation proved challenging due to high rotation in staff that are often overloaded with other tasks

(IRC, 2004). In South Africa, a public health researcher developed and promoted protocols to treat and respond to rape victims, emphasizing guidelines in collecting forensic evidence to ensure complete and proper evidence collection (Martin, 2002) and the provision of post-exposure prophylaxis for victims (Kim, 2000). To further improve collection of forensic evidence, South Africa also put into place laws that allow forensic nurses, not just certified district surgeons—who are inaccessible, unwilling, or unable to provide high-quality urgent care—to perform forensic exams of victims of intimate partner violence (Human Rights Watch, 1997; Bott, Morrison, Ellsberg, 2005). It remains to be seen, however, whether these policy reforms are effective. Still, evidence suggests that without trained personnel to manage, monitor, and generally support rape protocols, implementation is hindered (Western Cape Provincial Department of Health, 2002).

Meanwhile, outside the region, experience has shown protocols on how to treat and respond to cases of gender-based violence in the health setting are an important first step to guide healthcare staff, provided that they are trained on the protocols (Velzeboer et al., 2003). These protocols are not without their problems. Often, they are not widely distributed, understood, or applied. In South Africa, where rape victims must obtain police reports in order to receive forensic exams, the extra trip to police stations not only makes follow-through on reporting less likely, it also decreases likelihood for proper healthcare (Human Rights Watch, 1997; Martin, 2002). Although some places provide these services all in one place (see discussion of Thuthuzela centers below), such centers are few and far between in the region. Moreover, mandatory reporting to law enforcement has also been said to make health providers hesitant to ask women about violence due to their fear of getting involved in legal entanglements (Bott, Morrison, and Ellsberg, 2005).

Institutional reform in the health sector in the ECSA region is comprised mostly of training of health professionals. With the exception of South Africa, where a model for a health sector response to GBV was piloted and deemed successful (Jacob and Jewkes, 2001), much of the training appears to be limited to sensitization on gender relations and gender-based violence rather than specific procedures on treatment and response to GBV. Without the above-described protocols on how to respond to gender-based violence, it is not surprising that training is not grounded in concrete actions. Nonetheless, the sensitization training that was carried out effectively helped providers unlearn their own personal attitudes toward gender-based violence, as participating health professionals gained new recognition, for example, that a beating is never justified (Kim and Motsei, 2002). Still, experience has shown that trainings seeking to change lifelong attitudes and behavior reinforced by surrounding cultural norms may need to be longer than the few days usually allotted. Without long-term evaluations to determine impact on practices of providers, however, it is difficult to say what the minimum number of days should be. What is clear is that personal biases and experiences conflict with professional obligations when dealing with GBV and that a sensitization process is required to overcome these biases (Christofides and Silo, 2005).

Protocols and training for healthcare providers alone are considered inadequate for achieving lasting impact without system-wide reforms throughout the health institution (Heise, Ellsberg, and Gottemoeller, 1999). This strategy of system-wide reforms, referred to by experts as a "systems approach" consists of: reforming organizational policies and protocols to properly address GBV; infrastructure upgrades to ensure privacy and confidentiality; training of all staff—from top-level managers to receptionists, not only on treating GBV, but also in danger assessment safety planning and emotional support; ensuring staff have adequate resources, such as screening tools and directories to refer victims to other services, such as legal or counseling services; and providing STI prophylaxis and emergency contraception (Heise, Ellsberg, and Gottemoeller, 1999). Several of these provisions may not be feasible in resource-poor settings. Nonetheless, long-term strategies in the health sector should look toward the systems approach as a model intervention.

Similar approaches have been promoted when dealing with rape survivors. In South Africa, in particular, recommendations from pilot interventions have included one-stop centers where rape victims can receive medical, legal, and welfare and psychological aid; protocols to attend to victims and collect forensic evidence; and the provision of post-exposure prophylaxis as well as training for all staff (Martin, 2002; Western Cape Provincial Department of Health, 2002). More recently, Thuthuzela Care Centers were established by the National Prosecuting Authority (NPA), together with the Departments of Health, Social Development, and Justice and Constitutional Development, as well as the South African Police Services to improve the processes of reporting and prosecuting rape and other sexual offenses in a dignified and caring environment. Thuthuzela (meaning comfort in Xhosa) centers seek to lessen the trauma of sexual violence and to reduce secondary victimization of survivors by providing professional medical care, counseling, access to dedicated investigators and prosecutors, all in one place. Evaluation of Thuthuzela has found that the initiative has improved the processes of reporting and prosecuting rape and other sexual offenses and increased the conviction rates of rapists (UNICEF, 2006).

Community mobilization to improve the community response to violence and enlist key community groups in efforts to prevent gender-based violence is a common activity among NGOs in the region, especially as a feature of HIV/AIDS prevention or reproductive health programs. A few evaluated programs have shown that this strategy is effective in changing violence-related attitudes and behavior. The *Stepping Stones* program in Kenya, South Africa, Tanzania, Uganda, and Zambia (as well as The Gambia, Ghana, and the Philippines), which uses community-wide meetings, knowledge-building workshops, peer group discussions, and drama to challenge gender inequalities related to reproductive health issues and gender-based violence, has registered increased communication and gender equity between partners (Paine et al., 2002; Shaw and Jawo, 2000; Gordon and Welbourn, 2001; IGWG, 2002).

On a wider scale, Soul City, a health and development communications organization in South Africa (and now in eight other sub-Saharan countries), shares messages with its audience regarding key health and development issues through radio, television soap operas, pamphlets, and other media efforts. This method, known as educational entertainment or "edutainment" has been deemed by experts as largely promising in its ability to change attitudes and behavior (Bott, Morrison, and Ellsberg, 2005; Guedes, 2004, CDC, 2004). An extensive population-based impact evaluation of Series 4 of Soul City, for example, showed that it had reached 86 percent of the population, causing a 10 percent decrease of those who view intimate partner violence as a domestic affair and a slight increase in viewers' likelihood to report abuse (Scheepers, 200a; Scheepers, 2001b; Scheepers, 2001c; Usdin et al., 2005; Singhal, 2004). The belief that men have the right to beat their wives or that such beatings are socially acceptable did not change, but this may be attributed to the fact that violence was only addressed for the first time in Series 4, while attitude changes may take years of exposure (Scheepers, 2001a).

Numerous *behavior change communication* programs also address gender relations and gender-based violence in the sexual and reproductive health context, particularly with men. A program widely recognized as successfully inducing behavior change among its participants is the Men as Partners (MAP) program in South Africa by EngenderHealth and the Planned Parenthood Association of South Africa. Through educational workshops for men only and mixed-sex audiences, MAP has been able to achieve remarkable results: 82 percent of participants thought it was not normal for men to beat their wives, whereas 38 percent in the control group felt this way (Levack, 2001; EngenderHealth, 2002; IGWG, 2002). MAP, however, emphasizes that there is a need to maintain all male workshops to make participants feel comfortable; that young men are more accessible and, thus, should be targeted; that trained facilitators are necessary due to complex topics; and that follow-up is required for sustainability (EngenderHealth, 2002).

Box 4. Gender-based Violence and HIV/AIDS

Linkages between GBV and HIV/AIDS

Studies from around the world suggest that HIV/AIDS and GBV have a dangerous, complex relationship and may each increase the risk and impact of the other. The important interfaces of HIV and violence can be summarized as follows (Campbell, 2005): (1) epidemiological studies showing significant overlap in prevalence (Greenwood, et al., 2002); (2) studies showing intimate partner violence as a risk factor for HIV among women and men (e.g. Dunkle, Jewkes, Brown et al., 2004; Greenwood et al., 2002); (3) studies showing violent victimization increasing HIV risk behaviors, including intravenous drug use (e.g. Abdool, 2001; Choi et. al., 1998; Gilbert, El-Bassel, Rajah et al., 2002; Wyatt, Myers, Williams et. al., 2002); (4) emerging research showing immune system alteration from violence victimization in women (Woods et al., under review); (5) studies showing violence or fear of violence impeding or as a consequence of HIV testing (Gielen, McDonnell, Burke, and O'Campo, 2000; Maman et al., 2001; Maman et al., 2002); (6) studies showing partner violence as a risk factor for STDs, which increases the rate of transmission of HIV (Thompson, Potter, Sanderson, and Maibach, 2002); (7) data indicating that abusive men are more likely to have other sexual partners unknown to their wives (Garcia-Moreno and Watts, 2000); and (8) studies showing the difficulties of negotiating safe sex behavior for abused partners (Davila and Brackley, 1999; Wingood and Clemente, 1997).

"In addition, there are hypothesized but as yet untested relationships between increased HIV transmission and IPV through intimate partner forced sex, known as a frequent form of intimate partner violence (Campbell & Soeken, 1999; Maman, Campbell, Sweat, & Gielen, 2000). Forced vaginal sex may cause trauma, which increases the chance of transmission. In addition, abused women report forced anal sex as a frequent form of forced sex in violent intimate relationships, and anal sex is known to increase HIV transmission because of the same direct to blood transmission" (Campbell, 2005).

Interventions

The high prevalence of both gender-based violence and HIV/AIDS in ECSA calls for special attention to this relationship and for studies and interventions that address it aggressively. The broad political and donor support for HIV interventions provides an opening for addressing GBV. Gender and GBV can be integrated into HIV/AIDS prevention and treatment programs in various sectors, and some programs have proven successful, as discussed in the body of this report. Much research and pilot-testing needs to be done on how to best address HIV with respect to GBV and vice versa. Some potential strategic areas for integration of gender into HIV/AIDS programs include:

Research

Although the links between GBV and HIV have been documented somewhat, the studies tend to either focus on small geographical areas or either mostly on GBV or mostly on HIV (Campbell, 2005). Rigorous, comprehensive research needs to be conducted to better document the direct links so that programs and policies are as well-informed and effective as possible.

Promotion and Distribution of Dual Protection and Female-Controlled HIV Prevention Methods

Providing women with female-controlled HIV prevention methods such as female condoms and microbicides is essential considering women's and girls' limited power to negotiate sexual relations. Female controlled methods may reduce women's risk of violence in negotiating safer sex, in that women practice and control these methods themselves, and in the case of microbicides, women may even be able to use them without male permission or knowledge. Women's only access to HIV prevention information may be through family planning services; offering HIV prevention information and encouraging protection from both pregnancy and HIV is essential (IGWG, 2004).

Reproductive Health Services as an Entry Point

RH service providers are well-positioned to address both GBV and HIV through education and initial screening, and to make the necessary referrals if clients need further services (IGWG, 2002). The RH services setting is where women are most likely to obtain information on dual protection; integrating RH and HIV services makes sense in order to offer women the most opportunities to learn about HIV prevention (IGWG, 2004). Routine screening may be a good start to integrating GBV into these programs, however, there must first be a strong referral system in place for GBV-affected women to seek help.

VCT and PMTCT Programs

HIV counselors must be trained to discuss GBV as a possible consequence of women revealing their HIV status. Taking such consequences into consideration also means ensuring strict confidentiality. In PMTCT programs, staff must recognize the risk of GBV due to a woman's choice not to have children or breastfeed. Staff must respect women's decisions, while offering the widest range of possible options to HIV-positive women (IGWG, 2004).

Meeting the Needs of HIV-Positive Women

The increased stigma and discrimination, and the related risk of GBV HIV-positive women face mean women may need help in accessing healthcare, care giving support, and economic independence. PLHAs must be offered a full range of services and must have the opportunity to be involved in planning and decision-making related to HIV and GBV policies and programs (IGWG, 2004).

Community Mobilization/Individual Behavior Change

Community mobilization and BCC campaigns are prime arenas for opening community discussion of how gender and GBV impact health outcomes and for inviting communities to come together to advocate for positive change (IGWG, 2002). As stated in the health section on promising interventions of this report, evaluations of these initiatives suggest that they are effective in changing attitudes on GBV and are well-received.

Justice/Legal/Security

As the previous chapter highlighted, the justice sector plays a principal role in preventing gender-based violence. *Laws and policies*, as one would imagine, are essential tools that enable the justice sector to address gender-based violence. Although it is nearly impossible to determine if changing levels of violence are in fact due to laws and sanctions against it, since isolating its impact from other societal variables is difficult, laws against gender-based violence send an important message that violence is not tolerated by a society (Jewkes, 2002).

At the international level, governments throughout the region have signed treaties that pledge to protect women and girls against various human rights abuses, including gender-based violence as discussed on the previous section on women's rights in ECSA. The Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child are the most influential of these agreements, as they require signatory governments to implement reforms and report on their progress to the United Nations. All countries in ECSA have signed, ratified, or acceded to CEDAW except for Sudan. Nonetheless, an evaluation of CEDAW's global impact has shown that even in countries that have more developed legal systems than most of those in the ECSA region, many governments have failed to enact the required reforms or to enforce their relevant laws (Omale, 2000; McPhedran et al., 2000). For instance, although civil society organizations assessing CEDAW noted that in South Africa, grassroots organizations have used CEDAW to lobby for the Domestic Violence Act, in general, government is not aware of CEDAW (McPhedran et. al., 2000). All countries in the region have

ratified or acceded to the Convention on the Rights of the Child. Again, however, countries in the region are still a long way from harmonizing their laws with the CRC, never mind realizing the rights contained in the Convention there is relatively speaking much greater awareness of this international treaty (Johnston, February 2006 email).

Demonstrating this general disregard for CEDAW, few countries in ECSA have laws (civil or criminal) that explicitly criminalize intimate partner violence; rather, women must rely on general criminal codes on interpersonal violence that do not take into account the special nature and gender dynamics involved in intimate partner violence (Chuulu, 2001; Center for Reproductive Law and Policy, 2001). Moreover, marital rape is not recognized in most countries (Martinez, 1998; Center for Reproductive Law and Policy, 2001; World Organization Against Torture, 2003).

A few noteworthy legal reforms have taken place, however. First, in 1998, South Africa passed the Domestic Violence Act, which allows victims to file for protection orders against their abusers, among other provisions (Center for Reproductive Law and Policy, 2001). That same year, Tanzania eliminated a requirement that the complainant prosecute the case of domestic violence or rape themselves (Martinez, 1998). Still, while these reforms may help the safety and well-being of the victim (though some argue that protection orders, especially in resource-poor settings, do not do much to deter abusers), it is not certain what impact they actually have in prosecuting or preventing violence. Overall, there is much to be done in the area of legal reform.

Even when there are laws against intimate partner violence, they often go largely unrecognized, carry light sentences—of which just the minimum is often applied—or are compromised by customary law, which often dictates that husbands may use violence against their wives to a certain degree to discipline them (Center for Reproductive Law and Policy, 2001). Such is the case in Ethiopia, Kenya, South Africa, Tanzania, and Zimbabwe. In some cases, as in Zimbabwe, customary law allows perpetrators of domestic or sexual violence to pay "peace bonds" or a fee for damages to the victim's family in lieu of other punishment. Families often favor this option, undermining the safety and needs of the victim (Armstrong, 1998).

Furthermore, women often face social, economic, or logistical barriers in accessing the justice system, making necessary *institutional reforms* that facilitate the legal process. Special units in police stations especially for violence against women or other crimes against women and/or their children, like the Victim Empowerment Program and Family Child Services units in South Africa as well as the Victim Support Unit in Zambia, have been said to be produce some positive results, namely decreasing women's wait times at stations and getting cases to court sooner (Human Rights Watch, 1997, 2002). Such units have also been said to increase women's reporting of domestic and/or sexual violence as well as receive other legal, health, or counseling services (Bott, Morrison, and Ellsberg, 2005). However, on the whole, assessments have cited more weaknesses than strengths. More specifically, these special police units lack resources, infrastructure, and trained staff (Human Rights Watch, 1997, 2002). They are also said to be plagued with racism and classism, as black women and women of lower income strata are given less attention (Human Rights Watch, 1997). Furthermore, there is a lack of coordination by the main body of law enforcement, which often fails to refer cases to the special units. As such, Human Rights Watch advocates for the improvement of the law enforcement system overall (Bott, Morrison, and Ellsberg, 2005).

Sensitization and the training of judges and police on gender and gender-based violence, including those beyond special victim units, is another important way to improve the law enforcement response to gender-based violence. Evaluations consistently suggest that police and judges lack training and sensitization on how to handle GBV cases (Bollen et al., 1999; Human Rights Watch, 1997; Benninger-Budel, 2000; Mitchell, 2003; IRC, 2004). Again, however, initiatives to train law enforcement

on GBV have had mixed results. Training and engaging police and legislators can prove to be a powerful strategy, as they are great allies in the movement to prevent GBV (Michau and Naker, 2004). A qualitative review of police training by UNFPA in Namibia concluded that the intervention decreased rates of domestic violence, though long-term prevalence rates were not measured (UNFPA, 2003). The challenge, however, is being able to engage police and their managers to ensure their full participation and support in training (Human Rights Watch, 1997). Overall, though, there are no concrete results showing impact of training in the justice sector.

Community mobilization can help to achieve the much-needed reform of laws, policies, and services in the justice sector. Looking again at South Africa, an evaluation of Soul City found that their use of mass media and grassroots mobilization and advocacy facilitated and sped up the implementation of the Domestic Violence Act of 1998 (Usdin et al, 2000). Experience suggests that collaboration with various sectors in the community, including the for-profit sector can aid in achieving these reforms (Michau, Naker, and Swalehe, 2002). Engaging the justice sector itself to seek solutions to problems is an innovative method. South Africa's Department of Justice, for instance, recommended a task team be formed to develop guidelines for all those who handle sexual violence against women and also recommended the establishment of gender desks at magistrates' courts, gender sensitivity training, and legal reform. (Human Rights Watch, 1997). The impact of this initiative, however, was not measured.

Studies suggest that *individual behavior change* of women regarding their rights to live free of violence may be just as necessary as changing the behavior of legal officials or their perpetrators on these rights (see Mitchell, 2003). There are several institutions that educate women in the ECSA region on their legal rights, such as ADAPT in South Africa and the Education Center for Women in Democracy and the Nairobi City Council in Kenya (Levi, 1998; Michau and Naker, 2004). While their impact on achieving prosecution or other legal objectives is not clear since rigorous impact evaluations were not conducted, qualitative assessments have shown that their services are in demand but still quite under-funded (Michau and Naker, 2004; Human Rights Watch, 1997). Moreover, findings from an evaluation of a project providing similar services in Ecuador suggest that these services can benefit survivors of intimate partner violence. The evaluation found that "levels of domestic violence were similar among clients and non-clients before seeking services, but lower among clients after receiving the services" (Bott, Morrison, and Ellsberg, 2005). Notably, the evaluation pointed out that many women feared repercussions from their abusers if they pursued legal action. Thus, the intervention would have been more effective had it advertised services and outcomes regarding child support and custody. One must recognize, however, that in many ECSA countries successful results may be even harder to attain, because legal protections related to gender-based violence are in many instances less comprehensive than in more industrialized settings, especially where statutory law may be contrary to customary laws and norms, and where in any case resources to enforce laws are limited.

As this section has shown, even where there are laws and sanctions against gender-based violence, there is still much legal reform needed as well as many challenges in implementing new laws. It should also be recognized that legal recourse is not always the ideal means of action for women who are financially dependent on their partners or who do not want to break up their families. Therefore, laws regarding divorce, property rights, and child custody, as well as alternative sentencing are also important (Bott, Morrison, and Ellsberg, 2005).

Education/Youth

The education sector potentially has a pivotal role in preventing gender-based violence, as the school is highly influential in shaping gender norms and behavior (Mirembe and Davies, 2001). Moreover, as our discussion on risk factors pointed out, high levels of education can mitigate levels of intimate partner violence experienced by women. Regrettably, researchers have found schools across the

region—including the Democratic Republic of Congo, Ethiopia, South Africa, Sudan, Tanzania, Uganda, Zambia and Zimbabwe—to be the setting for much violence, including sexual harassment and sexual abuse of girls by fellow students and teachers (Human Rights Watch, 2001; Wellesley Centers for Research on Women and DTS, 2003; Mirembe and Davies, 2001; Leach, Machakanja and Mandoga, 2000; Leach, 2002; Mirksy, 2003; Best, 2005). Evidence suggests that sexual violence and abuse in schools contributes to girls' academic underachievement and institutional demoralization. In addition, it affects survivors' sexual health, later relationships, and broader gender relations (Mirsky, 2003).

Not surprisingly, therefore, *laws and policies* with respect to gender-based violence in the education sector are for the most part nonexistent. Studies revealed that countries across the region including Botswana, Ethiopia, Kenya, South Africa, Sudan, Tanzania, Zambia, and Zimbabwe lack policies on sexual harassment or abuse (Omaar and de Waal, 1994; Omale, 2000; Rossetti, 2001). Both educational authorities and teachers allow harassment and abuse to go largely unchallenged. South Africa provides an exception where the South African Department of Education, responding to widespread sexual harassment and rape in schools, formed a task force to study the problem and make policy recommendations. The result was the establishment of the Employment of Educators Act and Department of Education Guidelines in 2000, which calls for the removal of educators found guilty of sexual or physical assault or having a sexual relationship with a student (Bott, Morrison and Ellsberg, 2005). Nonetheless, the impact of these policies remains to be seen.

Some promising *institutional reform*s in schools have been implemented to address gender relations and gender-based violence in educational settings. For the most part, these initiatives have centered on increasing teachers' knowledge of and capacity to respond to and incorporate GBV in their curriculum and increasing the safety of schools for girls. Key findings from capacity-building programs for teachers in South Africa and Swaziland were that: (1) a "whole school" approach to training—similar to the idea behind the "systems approach" in the health sector—produces better results than select training of teachers or a training-of-trainers approach (Dreyer et al., 2001; and (2) a school must understand its role as one key actor in a community of actors (Michau and Naker, 2004). Regarding improving safety for girls in schools, in Tanzania, *mlezi* or female guardians to whom girls can report cases of sexual harassment and/or violence and receive counseling, have proven to increase girls' willingness to report victimization. An impact assessment of this intervention determined that 52 percent of girls in schools with a female guardian said they would report violence, while in the schools without this program, not one said she would (Mgalla et al., 1998).

There is a dearth of *community mobilization* initiatives within the education sector. However, small pilot experiences in Malawi and Zimbabwe (as well as Ghana) involving awareness-raising through seminars and workshops with students, their parents, teachers, government officials, and NGOs as well as the use of theatre and film for the youth community in general have demonstrated promise in mobilizing the community against GBV. Through informal qualitative methods, researchers found that these activities, the community-based approach in particular, increased willingness of parents to report abuse; encouraged girls to speak out about their victimization; spurred some policy reform by school officials; and allowed the community to confront it without putting girls at risk for retaliation (Leach et al., 2003; Bott, Morrison, and Ellsberg, 2005). In Malawi, researchers reported that the head teacher has started referring cases of teachers having sex with schoolgirls to the school committee, whereas in the past he would have ignored them.

Youth have also been employed to mobilize the community on gender-related issues mostly with respect to sexual and reproductive health, but in some cases, gender-based violence as well. A case in point is the Stepping Stones program, involving peer group discussions and drama organized and comprised of youth. Though impact of these initiatives on the prevalence of gender-based violence has not been extensively researched, findings from research in the field of HIV/AIDS has found that these

activities are at least successful in raising awareness of the problem and increasing gender equitable attitudes, even if changing behavior is not as easy.

Essentially the same has been said of *individual behavior change* programs with youth. An evaluation of a program called *Mobilizing Men to Care* in South Africa found that peer discussion groups helped girls become more confident, expressive, and outspoken in challenging exploitative gender relations within intimate and other relationships, and boys become more reflective and open to ideas of gender equality (Morrell, 2001). *Auntie Stella* in Zimbabwe—which uses mock advice columns to generate discussion on reproductive health issues, sex (including forced sex), communication in relationships, and gender relations—reported that the program appears to have led to increased communication with parents, elders, and peers about these issues among participants in the program, as well as to greater confidence in their ability to report potentially abusive situations and to advise their peers on issues related to reproductive health and rights (Kaim and Ndlovu, 1999; Harnmeijer, 1999).

Programs for youth that seek to protect girls from abuse, whether through school policies, training of teachers, guardians/counselors or peer discussions, must be careful not to reinforce the notion of girls as "victims" or being at fault for violence they suffered by their male peers. Research in Uganda has demonstrated that this is a risk. In that particular case, an evaluation found that rules and regulations designed for girls' "safety" led to policing girls more closely than boys, in part justified by the idea that girls "tempt" boys sexually; similarly, girls were encouraged to be "obedient" in a way not required of boys (Mirembe and Davies, 2001; Gao Rupta, 2003). Consequently, messages of gender equality imparted by educators were undermined.

Similar experiences in the United States illustrate the need to emphasize changing male attitudes and behavior. From the 1970's onward, schools and universities throughout the United States launched programs that taught children and young women to protect themselves by recognizing abuse, reporting threatening situations, and adopting safety precautions. The ultimate goal was to prevent "dating violence" or other forms of sexual coercion among students. A large number of in-depth scientific evaluations performed to assess the effectiveness of these programs indicate that while programs can improve participants' knowledge and willingness to report abuse, they do not appear to reduce victimization among participants compared to controls. Thus, many researchers and advocates argue against initiatives that focus primarily on increasing girls' ability to protect themselves and in favor of initiatives that aim to change male norms and behaviors and to promote positive models of forming relationships (Bott, Morrison, and Ellsberg, 2005).

Box 5. Gender-based Violence in Conflict-affected/Refugee Settings

Background

Armed conflict contributes to the culture of violence in many of ECSA's countries. The normative use of violence in society appears to be an important risk factor for high levels of violence against women. In settings plagued by war, these risks are multiplied. During the 1994 Rwandan genocide, for example, the United Nations estimates that between 250,000 to 500,000 women were raped (Hynes and Cardoza, 2000). Gleaning precise numbers on the prevalence of rape is problematic to begin with due to underreporting resulting from the stigma surrounding it. In conflict-affected settings, measuring the prevalence of rape and, consequently, war as a risk factor for rape or gender-based violence in general can be doubly challenging due to the inaccessibility of war-torn areas and the lack of comparison groups.

Nonetheless, it has been recognized by academics, activists, and media that, historically, rape has been used as a weapon of war to create fear in the civilian population in order to restrict freedom of movement and economic activity; to instill flight so as to facilitate the seizing of land and killing of male civilians; to ethnically cleanse through the "pollution" of blood lines; to demoralize the population by

denigrating women, which often represents honor of society; to boost morale of soldiers; and as a spoil of war (Gingerich and Leaning, 2004). Several studies report that in the conflicts of Burundi, the Democratic Republic of Congo, Rwanda, and Sudan, rape was systematically used as a weapon of war (IRC in Hynes and Cardoza, 2000; Mabuwa, 2000; Amnesty International, 2004a; Amnesty International, 2004c; Human Rights Watch, 2002; Hynes and Cardoza, 2000; Human Rights Watch, 1999; Gingerich and Leaning, 2004).

Promising Interventions

As discussed in the previous chapter, armed conflict exacerbates gender-based violence in many settings. Over the past decade, policymakers and international organizations have paid increasing attention to this issue. The circumstances of war, transitional governments, and at times mobile populations make addressing GBV even more complicated in conflict-affected settings. Given the instability and/or paralysis of local services during times of conflict or inaccessibility of services to refugees, external organizations working with these populations play a critical role in responding to GBV in conflict-affected or refugee settings.

Laws and policies in conflict-affected or refugee settings can have a limited effect in conflict-affected settings for the reasons discussed above, namely the instability of governments and the transitional nature of the population. Nonetheless, organizations working with refugee settings should abide by international guidelines to address GBV in conflict-affected or refugee settings. Accordingly, UNHCR has developed a set of field-tested guidelines highlighted below. Additionally, international laws and policies have the potential to protect women in conflict-affected settings from gender-based violence by denouncing gender-based violence as a violation of human rights. UN Resolution 1325, for example, states that parties to armed conflict must "take special measures to protect women from gender-based violence, particularly rape" (Amnesty International, 2004b). The impact of Resolution 1325 on protection of women at the outset is not evident, but such laws can be effective in punishing perpetrators. The International Criminal Tribunal for Rwanda, for example, found rape to be a fundamental part of genocide in the Akayesu case and in so doing, articulated a broad, progressive definition of rape and sexual violence (Askin, 1999). The case has been acclaimed as setting a ground-breaking precedent that shall allow for other convictions regarding rape as a weapon of war, though time will tell if it will and, more importantly, if it will prevent future rape in times of war. One should also note that there are thousands of rape cases that occur in the battlefields that never make it to the international courts, which would hardly have the capacity to handle the magnitude of these cases.

The International Rescue Committee has worked in countries across the region, including East Timor, Guinea, Kosovo, Liberia, the Republic of Congo, Tanzania, and more recently, Kenya, Rwanda, and Uganda, to address gender-based violence in conflict-affected and refugee settings. *Institutional response* initiatives, or more accurately, services provided, include and range from (1) medical and counseling services for survivors; (2) legal aid for survivors; (3) teacher training in primary and secondary schools; and (4) skills-building for women. *Community mobilization* and *individual behavior change* activities are comprised of mass media campaigns and awareness-raising among health providers and law enforcement (Bott, Morrison, and Ellsberg, 2005). Although there has been no rigorous evaluation of these activities, a recent assessment by an external consultant involving a review of documentation and key informant interviews determined that the Sierra Leone IRC program has achieved some success. In particular, the program increased survivors' access to free emergency medical care and forensic exams; increased awareness and sensitivity of staff; contributed to the successful prosecution of 10 cases of post-conflict sexual assault cases; improved the response of local courts to cases of sexual assault; and helped some women start their own businesses (Bott, Morrison, and Ellsberg, 2005; Guedes, 2004).

Sexual and Gender-Based Violence Against Refugees, Returnees, and Internally Displaced Persons: Guidelines for Prevention and Response (UNHCR, 2003)

These guidelines state that all programs serving displaced people must ensure protection from GBV. It suggests that the best way of addressing the problem is through a multisectoral program of both prevention and response activities. The guidelines offer practical advice, including guiding principles for designing strategies and carrying out activities aimed at preventing and responding to GBV among refugee and internally displaced populations.

Guiding Principals for Working with Survivors

1. Ensure safety of the survivor and her family at all times.
2. Ensure confidentiality of affected persons and their families.
3. Respect the dignity and choices of the survivor: interview her in private with only same-sex staff, ask only relevant questions, and avoid asking her to tell her story multiple times.

Guiding Principles for Developing GBV Programs:

1. Engage with the refugee community fully; with equal participation by men and women in planning, implementation, and monitoring and evaluation.
2. Integrate and mainstream activities into existing programs and sectors.
3. Ensure accountability at all levels by all who are involved.
4. Ensure coordinated multisectoral action by all actors.

Recommended Prevention Strategies:

1. Influence changes in socio-cultural norms: IEC campaigns to promote changes in community gender norms and knowledge of human rights; ensure equal gender balance and participation in leadership; empower women through activities that promote their independence, self-reliability, leadership, and decisionmaking ability; and involve men, children, and youth.
2. Rebuild family and community support systems that uphold respect for the equal rights of all members of the community: develop recreational and social activities; and encourage resumption of religious and spiritual activities, targeting religious leaders as partners for dissemination of messages on women's rights and GBV prevention.
3. Create conditions to improve accountability: raise all staff's awareness about guidelines on GBV and ensure compliance with standards of accountability and codes of conduct.
4. Design effective services and facilities: register all individuals and provide each with a registration card; inform refugees about their rights and benefits, including ways to access services, national laws, UNCHR policies and guidelines, and mechanisms and procedures for filing complaints about GBV; encourage community involvement at every stage; promote gender-balanced distribution of food and other commodities; design RH programs and security and safety programs; be sensitive to host population and extend services to local population; and mainstream gender issues into all stages of program planning and implementation.
5. Influence the Formal and Legal Framework: increase knowledge of the formal and traditional/customary legal systems of host country; provide awareness-raising and training to professionals in those systems on GBV and human rights; strengthen national laws and policies to protect human rights and promote appropriate sanctions for perpetrators.
6. Monitor and document incidents of SGBV.

Recommended Survivor Service Strategies:

1. Develop community education and awareness activities around the importance of reporting and how and where to get help.
2. Direct services for survivors: train all staff how to respond; set up referral, reporting, monitoring, and evaluation mechanisms; empower the refugee community to respond; respond to health/medical needs,

including forensic exams, post-exposure prophylactics, and treatment for injuries; meet psychosocial needs; provide security and safety through an effective law enforcement presence; and ensure timely and appropriate legal justice.

Multisectoral Coordination

As already discussed, gender-based violence is a complex issue that originates from and is supported by factors at various levels—individual, relationship, community, and society. Because the community and society play such important roles, as our discussion on risk factors emphasized, all sectors must take part in efforts to eliminate gender-based violence. Thus, just as there is not one answer to the question "Why do men abuse women?" there is also not one strategy to prevent the abuse. Health providers may be able to detect abused women, but if laws and sanctions are not in place to convey that it is intolerable, men will continue to abuse their partners. On the other hand, even with the laws in place, law enforcement officials cannot prosecute cases of gender-based violence without adequate forensic evidence, which health providers must provide. Still, these efforts are unlikely to be effective if social norms that justify violence against women or that put women in an unequal position are so pervasive in schools and other community institutions that perpetrators do not experience negative consequences for their behavior and women do not report the violence or do not have the economic means to escape their abusers. Recognizing these findings, a multisectoral and multilevel approach involving collaboration by the justice, health, education, and other sectors is necessary to address gender-based violence.

At the level of *laws and policies*, a valuable multisectoral approach involves networks that allow civil society organizations and others working on gender-based violence to share information regarding good practices and lessons learned in programming as well as research findings. These organizations can also help pool efforts to lobby government and change laws and policies. One notable example, as highlighted in a multiprogram review of hundreds of organizations working on GBV, is the KwaZulu Natal Network on Violence Against Women, part of the National Network of Violence Against Women in South Africa (Michau and Naker, 2004). These networks played an integral role in facilitating and ensuring the implementation of South Africa's Domestic Violence Act of 1998 (Usdin et al., 2000).

Particularly promising are programs that seek to meet the many needs of GBV survivors either through adequate and proper referral to other services or sponsoring holistic provision itself. This multisectoral *institutional response* may take shape in the form of referral networks, such as the *Vezimfilho!* program in South Africa (Jacob and Jewkes, 2001; Bott, Morrison, and Ellsberg, 2005), which coordinates health, legal, psychosocial, educational, and financial support services, or one-stop centers that provide most, if not all of these services, such as South Africa's Saartjie Baartman Centre for Women and Children (Els, 2002). Case study assessments indicate that these are promising interventions. One-stop centers, in particular, are considered promising ways to help GBV survivors receive the services that they need, given that many survivors lack time and resources to travel to various locations.

Programs that combine *community mobilization* and/or *individual behavior change* in various or all sectors are especially noteworthy for their prevention methods. Raising Voices in Uganda is an example of one such program that has achieved some success. The program uses a community-based approach that involves first gathering baseline information to assess local beliefs about domestic violence; raising awareness in community and professional sectors about domestic violence and its negative consequences for the family and community; building networks of support and action among community and professional sectors, and integrating action against domestic violence into everyday life and systematically within institutions. A 2003 qualitative assessment found that the program contributed to substantial individual, relationship, and community changes, including decreased levels of physical, emotional, sexual, and economic violence against women in the home. Men were said to have changed their behavior in response to reduced tolerance of violence by local councils, police, and the community

at large (Raising Voices, 2003; Michau and Naker, 2004). The Malawi Human Rights Resource Center's approach is another well-known example; they not only sponsor symposiums with men to achieve individual behavior change, but they also complement this grassroots mobilization with leadership from above by using male leaders to mobilize the community against gender-based violence (Michau and Naker, 20024).

EARLY MARRIAGE

Literature on early marriage and bride price tends to provide recommendations for interventions to prevent the phenomenon rather than results of successful interventions, as few interventions have been documented that specifically aimed to impact age at marriage or bride price. Interventions which may have an impact on age at marriage or married girls' empowerment may not be framed as "early marriage interventions," but rather focus on providing reproductive health information and services to adolescents, promoting girls' education, or providing skills training or micro credit schemes to girls. Therefore, it is possible that this review inadvertently overlooked such programs. The programs documented below either were not formally evaluated or consist of new programs still in progress, hopefully to be evaluated at a later date. The categories below are the suggested types of interventions for early marriage put forth by UNICEF (2001) and are reflected in several other publications (Murphy and Hendrix-Jenkins, 2002; Elliot, 2004).

Legal and Policy Change

Governments must review customary and civil law in light of internationally agreed human rights standards on marriage (UNICEF, 2001; Murphy and Hendrix-Jenkins, 2002; Jensen and Thornton, 2003). Once marriage age laws are appropriate, measures must be taken to ensure adherence, including registering births and marriages (UNICEF, 2001). Moreover, to prevent early marriage, it is also essential to create an atmosphere in the community in which sensitive topics such as marriage, sexuality, and GBV and the issues surrounding them can be discussed openly. "Benefits of delaying marriage for husbands, wives, families and communities need to be shared with religious and community leaders," (UNICEF, 2001) as well as government personnel (Murphy and Hendrix-Jenkins, 2002). Cash incentives have been introduced in some countries to encourage parents to delay their daughters' marriages. In India, for example, families are eligible for a certain amount of additional income if girls are not married when they reach age 18 (Murphy and Hendrix-Jenkins, 2002).

Support for Physical and Psychological Well-being

At the very least, programs should provide information on reproductive health and human rights to youth and ensure access to reproductive services and information for both married and unmarried youth (UNICEF, 2001; Murphy and Hendrix-Jenkins, 2002). In addition, programs can provide assistance to women who run away to escape abusive marriages. "In Kenya, for example, an enterprising Maasai woman helps such girls find refuge in the boarding school she has created in the town of Kajiado. Their rescue is often organized with the help of mothers who are willing to brave the stigma of supporting them" (Russell, 1999, in UNICEF, 2001). The Population Council and the Ethiopian Ministry of Youth, Sports, and Culture are also currently working to implement a program in Addis Ababa to "promote girls' safety and social networks" (Elliot, 2004) (see box 5).

Education for Empowerment and Intellectual Development

Keeping daughters in school (UNICEF, 2001; Murphy and Hendrix-Jenkins, 2002, and making schools more girl-friendly may also be important ways to combat early marriage. This includes "building more schools closer to communities… more female teachers, improving relevance of curriculum and

quality of teaching, flexible schedules to allow girls to meet domestic responsibilities, in-school childcare facilities, penalties for male teachers who seduce girl students, and separate sanitary facilities for boys and girls" (UNICEF, 2001). The expansion of non-formal education for girls who have left school may be greatly beneficial to married girls (UNICEF, 2001).

Box 6. Promising Program: Berhane Hewan "Light for Eve"

The Population Council and the Ethiopian Ministry of Youth, Sports, and Culture are currently in collaboration to implement an intervention to delay early marriage in rural Ethiopia. "The program seeks to delay early marriage, reduce girls' social isolation, and support girls seeking to escape early marriages or exploitive situations, including domestic work. The community called the program "Berhane Hewan," which means "Light for Eve" in Amharic. With adult women acting as mentors, groups of married and unmarried girls ages 10–19 meet for non-formal education and other activities that are of the girls' choosing. Roughly half of the mentors have experience in providing non-formal education, while the other half are respected women drawn from the community. The groups of unmarried girls meet five days a week and the married girls meet once a week. The meetings, which take place in local community structures, such as a community hall or barn, have the effect of collectivizing girls, giving them safe and reliable spaces to meet, and building new and visible roles that are supported by the community" (Erulkar and Mekbib, 2005).

Support for Improved Economic Status

Since early marriage is both a result of and a contributing factor for poverty, it is important to address families' economic pressure to marry girls early, as well as women's economic dependence on men (UNICEF, 2001; Murphy and Hendrix-Jenkins, 2002). Activities may include "training in livelihood skills, support for teenagers in the labor market, and ensuring that marriage is not a pre-condition for eligibility for schemes such as micro-credit programs and savings clubs" (UNICEF, 2001).

FEMALE GENITAL CUTTING

Interventions that address FGC/M include those that take the legal approach, usually by criminalizing the practice, and the health sector approach, either through medicalization of the practice or engaging health workers in community mobilization and behavior change efforts, which comprises a majority of interventions given how culturally embedded FGC/M is. Behavior change and community mobilization efforts include information, education, and communication (IEC) programs, employing "positive deviants" to lead others in abandoning the practice, encouraging alternative rituals in place of FGC/M as cultural/traditional coming of age practice, and working with excisors to stop performing FGC/M. Below is a sampling of these interventions from various African countries that practice FGC/M.

Legal

Currently, at least 11 African countries have outlawed FGC/M, but in ECSA, only Djibouti, Kenya, Sudan, and Tanzania have criminalized the practice of FGC/M (UNFPA, http://www.unfpa.org/gender/faq_FGC/M.htm#21; Falsom, 2003). In Sudan, only the most extreme forms of FGC/M are outlawed, and in Kenya, a Presidential Declaration has denounced the practice (UNFPA, http://www.unfpa.org/gender/faq_FGC/M.htm#21). While laws provide the legal platform for activities and rejection of the practice, they can hardly change deeply entrenched cultural practices (Bodiang, 2003). Often times, people persist in secrecy (Bodiang, 2003). Promising approaches to effectively implement laws involve awareness raising about the law; enforcement of the law, particularly by punishing excisors; and establishment of a hotline where individuals can report cases of FGC/M, as

Burkina Faso's National Committee for the abandonment of FGC/M did (Bodiang, 2003). By and large, however, there are few documented programs that take the legal approach—presumably due to its weak impact.

Health

Evidence shows that a potentially effective way to stop FGC/M through the health sector is by *employing health workers* as educators and advocates of abandoning the practice. Such interventions can work at the individual, community, or policy level. For instance, CARE's pilot FGC/M abandonment projects in East Africa, which operated from 1999–2002, incorporated FGC/M abandonment initiatives in the organization's wider reproductive health programs, particularly by using community health workers to educate and foster debate on FGC/M from a rights-based approach, but also by partnering with ministries and community leaders to advocate against FGC/M (Igras et al., 2004). Preliminary evaluation results demonstrate that in Kenya and Ethiopia, the project successfully increased knowledge regarding FGC/M's harmful effects, and in Ethiopia, it increased the number of people wanting to end the practice (Igras et al., 2004).

A dangerous trend in the health sector is the *medicalizaton* of FGC/M; in other words, the use of medical professionals (physicians, nurses, and midwives) to perform the procedure. The trend comes as a result of growing recognition of the health risks associated with FGC/M, including the possible role of FGC/M in HIV transmission (PRB, 2005). Having the procedure performed by a health professional, preferably in a health facility is said to minimize health risks and decrease pain (Njue and Askew, 2004). Whether medicalization minimizes health risks or not, it does not detract from the fact that FGC/M is a violation of human rights. Nor does it eliminate the longer-term obstetric, psychological, sexual and emotional problems FGC/M can cause.

Behavior Change and Community Mobilization

IEC programs that seek to put an end to FGC/M do so by raising awareness regarding its harmful effects and related myths, promoting dialogue, support women's empowerment, developing community-based solutions, and encouraging community declarations against the practice. Like any IEC campaign, to be effective in stopping FGC/M, it should be tested and use local knowledge (Bodiang, 2003). Bodiang (2003) finds that programs that are most effective in changing behavior are those that include specific behavior change interventions (for example, building women's abilities to resist the pressure to excise) that are further supported by community mobilization efforts that enlist the community to support the change. One well-cited example of this is a basic education program by Tostan, an NGO in Senegal that teaches women hygiene, problem solving, women's health, and human rights. Evaluation of the project determined that the program raised awareness about FGC/M and reproductive health and human rights; significantly changed attitudes toward FGC/M, including parents' regret for cutting their daughters and denouncing FGC/M; and perhaps most importantly, decreased prevalence of FGC/M of girls 0–10 years-old (Diop et al., 2004).

Using *positive deviants* to encourage the abandonment of FGC/M has also proven effective in some settings. The use of positive deviants generally involves "identifying and mobilizing individuals who have challenged or 'deviated' from conventional societal expectations, and explored successful alternatives to cultural norms, beliefs, or perceptions in their communities, to act as role models for abandoning (FGC/M)" (PRB, 2005). In Egypt, for example, CEDPA's Female Genital Mutilation Abandonment Project (FGMAP) mobilized doctors, religious leaders, teachers, and other members of the community to give workshops, presentations, and home visits to raise awareness on FGC/M. Research on the impact of the project's use of the positive deviant strategy showed that not only did it cause the

"deviants" to further oppose FGC/M, but also that where attitudes changed, these positive deviants, particularly prominent community members, played a strong role in creating that change (CEDPA, 2004).

Adopting *alternative rituals* to symbolize and celebrate a girls' coming of age appears to be a key strategy in eliminating FGC/M. These alternative rituals, which may include joyful festivities and activities that educate the girl of the role she will play with respect to sexuality and motherhood, are "healthy initiation celebrations" that take the place of and/or exclude circumcision (Bodiang, 2003). One such evaluated project is MYWO in Kenya, which combines BCC and community mobilization efforts with alternative rites strategies (Folsom, 2003). An assessment of MYWO's alternative rites component found that families not participating in alternative rituals were more likely to already not be cutting their daughters and to express regret for those already cut than those not participating in the alternative rituals. Additionally, as would be expected, these families were more likely than those not participating in the alternative rituals to have circumcised their daughters ages 15 and over. These findings point to the possibility that alternative rituals simply coincide with the abandonment of FGC/M, or it could be that engaging in alternative rituals actually is a necessary precedent to abandonment (Chege, Asku and Liku, 2001). Only in the latter case would alternative rituals be a necessary component to prevention programs (Chege, Asku, and Liku, 2001). While more research is necessary to fully understand the role and impact of alternative rituals, qualitative assessments suggest that those who practice FGC/M do look for alternatives to the practice (Folsom, 2003).

Some programs have sought to *focus prevention efforts on excisors* alone. Educating traditional circumcisers about the health risks associated with cutting and/or providing alternative means of income has been tried over the past decade in various places, but most reported experiences have been unsuccessful (Bodiang, 2003). Experience shows that while such efforts may at best get a few individual practitioners to stop performing the procedure, they have no effect on demand. Such strategies must be accompanied by extensive awareness campaigns addressing the community as a whole, or else families will simply seek other providers, and traditional practitioners will return to cutting within a short period of time (Bodiang, 2003).

Each of the above strategies alone has little effect on the elimination of FGC/M. As the discussion on the individual strategies has shown, they are each dependent or related to one of the other interventions. Laws are ineffective if people are not made aware of them. IEC efforts, including community mobilization can be made more effective through the use of positive deviants, which may include health workers. Alternatives must be sought for both families practicing FGC/M and those performing it. Additionally, programs that employ these strategies collectively may be especially successful. In Kenya, where a presidential decree condemned the practice in 1982, the MYWO project implemented IEC efforts; mobilized the community, including the media, health workers, leaders, and other positive deviants; and after two years, promoted alternative rituals to FGC/M. Evaluation results show that before the intervention, 90 percent of the population had been cut, but six years later, only 82 percent had been cut (Falsom, 2003). While it is difficult to isolate the impact of the project since there was no control group measured for circumcision levels, the evaluation did find a greater rate of attitudinal change among project participants versus non-participants (Chege, Asku, and Liku, 2001; Falsom, 2003.)

HUMAN TRAFFICKING

Interventions to address trafficking, including sex trafficking, in ECSA are limited. While small efforts are being mounted by local NGOs, governments in East and Southern Africa especially have been virtually non-responsive to the problem (IOM, 2005). Adepoju argues that this is likely due to the fact that most governments in those sub-regions (less than one-third) do not perceive trafficking as a problem (IOM, 2005). However, she highlights some notable efforts by governments in the region, including a consulate set up in Beirut in Ethiopia to provide support to its female nationals being abused and exploited in Lebanon; and South Africa's Law Reform Commission's investigation of human trafficking, which seeks to develop legislation to punish traffickers and protect victims. Highlighted below are international best practices related to sex trafficking documented by the U.S. State Department Trafficking in Persons Report (the text is taken directly from the U.S. Department of State's Trafficking in Persons Report, 2005).

Laws and policies against trafficking:

- *Mali/Senegal/Burkina Faso: Implementing Bilateral Anti-Trafficking Accords.* In 2004, the Government of Mali signed bilateral accords with the Governments of Senegal and Burkina Faso to fight child trafficking. As a result, Senegal repatriated 54 Malian children and Mali repatriated 20 children to Burkina Faso.

- *Global: Fighting International Child Sex Tourism.* The World Tourism Organization, End Child Prostitution, Child Pornography, and Trafficking of Children for Sexual Purposes (ECPAT), and Nordic tour operators created a global Code of Conduct for the Protection of Children from Sexual Exploitation in Travel and Tourism in 1999 (www.thecode.org). This code requires signatories to: 1) Establish a corporate ethical policy repudiating the commercial sexual exploitation of children and introduce such clauses in suppliers' contracts; 2) Train tourism personnel; 3) Provide information to travelers; and 4) Report annually on their progress. As of March 2005, 100 travel companies from 18 countries had signed the Code. The world's largest tour operator, JTB, along with the Japanese Association of Travel Agents, signed this spring.

- *The Republic of Korea (R.O.K.): Cracking Down on Prostitution and Trafficking.* In response to a petition by a million Korean women, the R.O.K. passed two significant anti-prostitution and anti-trafficking laws in 2004 aimed at combating the commercial sexual exploitation of women and girls. The laws not only stiffened penalties for trafficking and prostitution, established support mechanisms and facilities for victims, and provided for public awareness and education campaigns, but also reflected the input of the NGO community and the government agencies charged with responsibility for enforcement. The Government of the Republic of Korea backed its new laws with both political will and resources. The new legislation has resulted in the rescue of over 200 victims and the arrests of over 500 traffickers and sex-buyers. The government's efforts have also produced a visible reduction in the commercial sexual exploitation of women and girls and markedly raised public awareness of trafficking and prostitution.

Improving response by authorities:

- *Czech Republic: Establishing Screening and Identification Procedures.* In cooperation with NGOs, the Government of the Czech Republic has formalized its victim screening process by creating a list of ten questions for police to use. Detailed questions are often essential for law enforcement to discover a human trafficking case. With EU support, the Czech Government also established an intranet site for police on how to identify and assist victims. The site, used on a daily basis, includes definitions of human trafficking, ways to identify trafficking victims, how to proceed with trafficking cases, and which NGOs to contact for victim assistance. A portion of the site is under development and will allow officers to refresh training independently.

- *Morocco: Addressing Trafficking-related Crimes of International Peacekeeping Forces.* Following allegations that Moroccan peacekeepers abused civilians under their protection as part of the UN peacekeeping mission to the Congo, the Government of Morocco took quick and vigorous action. It strongly condemned the act, quickly launched an investigation, and arrested six implicated peacekeepers, announcing that they would be court-martialed. Press reports indicate that Morocco dismissed the commander of its peacekeeping contingent in the Congo and his assistant. Four additional perpetrators were also arrested and are expected to face justice.

Protecting the most vulnerable:

- *Malawi: Creatively Combating the Prostitution of Children.* People Serving Girls at Risk (PSGR), a local Malawian NGO, takes an innovative approach to help girls leave prostitution through social reintegration and building support networks. Male and female staff, "peer educators," go undercover where girls solicit customers and pretend to be prostitutes or clients to establish relationships of trust. The girls in prostitution are offered social and medical services and legal advice. PSGR helps form "watchdog groups" that are vigilant against girls joining or being lured into the commercial sex industry. These groups visit families and offer counseling to vulnerable girls.

- *Philippines: Public-Private Partnership.* NGO Visayan Forum Foundation (VFF) operates four shelters for victims at major Philippine ports, including Manila and Davao. The Philippine Port Authority, police, and shipping companies, including the country's largest passenger shipping company, identify victims, mainly children, transiting the port and turn them over to VFF, which provides housing and protection. VFF then works with police to facilitate investigations and with the Department of Social Welfare and Development (DSWD) to repatriate and counsel victims. At the Davao shelter alone, VFF serves up to 45 victims a week.

- *Slovenia: Protecting The Most Vulnerable.* The Project Against Trafficking and Sex and Gender Based Violence (PATS) provides trafficking awareness information and assistance to asylum-seekers most at risk, especially single females and children separated from their parents. Key elements of the project include: One-on-one information sessions with a social worker for those at risk; information on warning signs and the dangers of falling victim; information about where potential victims can access assistance; access to specialized assistance and protection for victims identified in the asylum procedures; and access to asylum procedures for identified trafficking victims. All at-risk asylum-seekers receive a small book, the purpose of which is disguised, that contains trafficking information and assistance contacts throughout Europe. The project is jointly administered by the Ministry of Interior's Asylum Section, two local NGOs (Kljuc and Slovenksa Filantropija), and the United Nations High Commissioner for Refugees (UNHCR) in Slovenia. Slovenia's Ministry of Foreign Affairs actively promotes the project regionally with other governments.

Raising awareness about the problem:

- *Brazil: Outreach to Passport Applicants.* To alert potential victims to the dangers of international trafficking, the Brazilian Government launched an information campaign for women traveling abroad. Each female Brazilian passport applicant between the ages of 18 and 35 receives a leaflet with her new passport stating, "First they take your passport, then your freedom." The leaflet includes a list of key human trafficking indicators and provides a national federal police contact number for filing complaints. The campaign was launched in October 2004 by the Ministry of Justice's Secretariat for Human Rights with the assistance of the United Nations Office of Drugs

and Crime. It is part of a larger public awareness campaign using leaflets, posters, and radio spots to prevent women from falling victim to international trafficking for sexual exploitation.

- *Indonesia: Involving Local Muslim Leaders.* Many young girls from impoverished families are educated in Islamic boarding schools (*pesantren*). The Asia Foundation supports the Fahmina Institute to provided anti-trafficking training materials to *pesantren* teachers, and to male and female preachers. In January 2005, The Asia Foundation helped organize a meeting of *pesantren* leaders, resulting in 32 schools forming the Pesantren-Based Alliance for Eliminating Trafficking in Persons in East Java.

- *Portugal: Raising Public Awareness.* In October and November 2004, an anti-trafficking movie, *Dark Night* was released for commercial viewing in Portuguese theaters. With a popular, well-known Portuguese cast, it ran alongside first-run American movies at mainstream cinemas. *Dark Night*, which was awarded the Portuguese 2005 Best Film and Best Actress awards, raised public awareness. Portuguese filmmaker Joao Canijo collaborated with police and NGOs to better understand trafficking and to portray it as distinct from illegal immigration in the film.

CROSS-CUTTING CONCLUSIONS REGARDING PROMISING INTERVENTIONS

Although often taken for granted, gender equitable norms lie at the core of most of the above-described promising interventions. Ultimately, as our discussion on risk factors emphasized, the work of GBV prevention is to transform the nature of relationships between women and men and the models of masculinity and femininity acceptable in the community, as well as to increase women's status in the community (Michau, Naker, and Swalehe, 2002). Thus, in terms of programming, it is not surprising that *promising interventions* to prevent gender-based violence first delve into the issue of gender inequity through behavior change communication and community mobilization.

As the previous section just highlighted, *a multisectoral approach* is essential in preventing and responding to gender-based violence; this cannot be stressed enough. Each sector has its role to play in helping survivors of GBV and preventing incidents of GBV: health providers detect cases and treat survivors while promoting healthy relationships through sexual and reproductive health programs; law enforcement puts sanctions on perpetrators of gender-based violence; and educators impart the message that gender-based violence is a violation of human rights. It is imperative that these roles are coordinated to be fully effective.

A *multilevel approach* is necessary. Common sense practically dictates that individual behavior change, community mobilization, the reforming of institutional response, and the reforming of laws and policies are all vital strategies to challenging this multifaceted problem. Still, too many initiatives reviewed addressed only one of these levels of intervention. The legal sector provides a good example: implementing laws to punish perpetrators of gender-based violence is likely to be ineffective when police and judges fail to enforce the laws because communities consider violence to be the norm and when women are unaware of their legal rights related to violence (Bott, Morrison, and Ellsberg, 2005).

Similarly, a need for *top-down as well as bottom-up* leadership and mobilization is evident. As discussed above, for example, Rwanda IRC's attempt to train health ministry officials failed due to the lack of commitment from ministry leaders. Activities that mobilize citizens of communities *and* engage leaders in the community are especially successful in changing attitudes and, at least according to preliminary findings, behavior. Without support from ministries or municipal leaders, however, interventions are not taken seriously and at times not fully carried out.

Working with men is a key strategy. Throughout the review, examples made evident that working with men is a key strategy to prevent gender-based violence. Behavior change strategies in the health sector have shown that inequitable gender attitudes can be unlearned and that doing so can contribute to healthier relationships. In schools, focusing initiatives on girls as "victims" to be protected without addressing patriarchal attitudes and behavior among boys simply reinforces the notion that gender-based violence is acceptable. Throughout society and the community in general, men are leaders that can pave the way for change.

Targeting youth is perhaps one of the most efficient ways to prevent gender-based violence, albeit in the longer term. Evidence suggests that youth are more open to change, including their attitudes and behavior regarding violence. (Bott, Morrison, and Ellsberg). Nonetheless, such strategies should not undermine the need to work with the community overall.

In that vein, to promote community ownership of GBV as a problem, *community mobilization should involve all members of the community*, from civilian beneficiaries to health and legal service providers, teachers, and community leaders. Individual behavior change is not enough; it must be linked to and reinforced by norms and messages in the surrounding community as well.

Preventing gender-based violence is a long-term investment. Raising awareness is only the beginning of the processes of influencing change (Michau, Naker, and Swalehe, 2002). Individual behavior change and community mobilization, as experiences of many programs reviewed made evident, requires long-term follow-up that may take years. Additionally, helping individuals think through alternatives to violence and creating informal and formal systems of accountability and support is essential for individuals to sustain a change in attitude and behavior (Michau, Naker, and Swalehe, 2002). Too often, however, limited funding allows for only short-term support.

VI. CONCLUSION

Gender-based violence, as this report has argued, is an intricate issue that, even after decades of research, still remains perplexing in many ways. Understanding why women and girls are abused requires the analysis of factors at the individual, relationship, community, and society levels. Moreover, there is no common formula of these factors for each perpetrator and/or victim; instead the interplay of the various factors creates distinct milieus that are less and more apt for violence. Nonetheless, a rather persistent element woven through many of the factors is the unequal status of women and male dominance—whether it is traditional social norms or laws that condone violence against women, friction over women's empowerment, or women's lack of legal rights. Even when considering other factors, like a history of violence in the family, one cannot help but come back to the fact that women are the overwhelming victims of various types of gender-based violence because it is widely accepted by society. With this knowledge in hand, governments and donors can begin to formulate and take concrete actions to address gender-based violence.

While individuals must be held accountable for the ultimate choice to be abusive toward someone based on their gender, we must recognize that individuals are influenced by their surroundings. As such, interventions to prevent gender-based violence must address each level—individual, community, and society—through multisectoral coordination. Although much research still remains to be done to better determine risk factors for GBV as well as effective interventions to respond and prevent the problem, GBV victims can no longer wait for the "best approach." As much as the above findings are salient and should be implemented to the extent possible, the urgent nature of GBV, when victims' lives are at risk, begs local, national, and international communities to act immediately.

ANNEX 1: MEASURING AND DETERMINING GBV RISK FACTORS IN ECSA

Methodological Challenges in Measuring Risk Factors

Notwithstanding the difficulties in measuring levels of violence itself (particularly under-reporting by women due to stigma, failure to recognize violence, and varying methods of surveying), measuring the risk factors related to gender-based violence is challenging for a number of other reasons. First, few studies have considered the multilevel factors in the ecological model. Most studies to date have looked only at individual and relationship factors. Yet, as this review has shown, socio-cultural factors are particularly important in explaining why women are the predominant victims of intimate partner violence. On the other hand, community and societal factors are difficult to operationalize through representative, measurable variables. Moreover, studying the impact of societal factors requires cross-cultural comparisons. While there have been a handful of studies (for example, Levinson, 1989 and Counts, Brown, and Campbell, 1999) that do take a cross-cultural approach, even fewer, if any, have studied socio-cultural factors as well as individual and community factors.

Furthermore, the relationships between the factors can be difficult to measure in statistical terms. First, several variables, such as poverty and educational status, may be highly correlated to each other and, therefore, may inflate or confound their relationship to violence. More sophisticated econometric models can help control for these effects, but even then, the exact impact on levels of violence may be impossible to determine. Second, understanding the relationship between perpetration as well as victimization of violence and a number of risk factors, such as poverty and alcohol use, would benefit from longitudinal analysis (analysis over time), as these factors may certainly be outcomes of gender-based violence rather than predictors. Most surveys, however, rely on cross-sectional data (data sampled at one point in time).

Parameters for Risk Factors Included

Given the above methodological issues, it is challenging to do a review of risk factors with relative confidence that the findings are scientifically sound. Other reviews, mostly those looking at risk factors in North America, have imposed stringent criteria for the inclusion of study findings in their reviews (see Hotaling and Sugarman, 1986). Such criteria include the analysis of comparison groups (particularly important for non-population based studies) and statistical modeling to measure the significance of risk factors identified.

In Africa, however, where conclusive research on risk factors for GBV is weak and where existing research is concentrated in a handful of countries, namely Ethiopia, Kenya, Rwanda, Uganda, and South Africa, imposing such criteria would severely limit the content of this review. Some studies, for example, looked at special populations, such as conflict-affected populations or those involved in clinical trials. Meanwhile, many studies use qualitative research methods only. Few employed multivariate statistical analysis. Thus, all risk factors arrived at using some form of primary research at least twice, whether qualitative or quantitative, were included in the review. Statistically measured risk factors are summarized here.

Risk Factor	Findings	Country	Source	Limitations
Society				
Social norms that justify VAW	Approximately 50 percent of women who ever experienced violence believe that her partner is justified in hitting her: (a) for any reason at all; (b) if she goes out without telling him; (c) if she neglects the children; (d) if she answers back; (e) if she refuses to have sex with him; or (f) if she does not prepare food.	Zambia	Kishor and Johnson, 2004	Statistical significance on rates of IPV not computed.
Social norms that justify VAW	Opinion surveys found that women think men are justified in abusing them if they are adulterous. Moreover, only 84 percent thought that illness was a reason for refusing sexual relations, but only 26 percent thought lack of desire was a good enough reason. Focus groups confirmed the notion that women should be obedient to prevent violence. (N=449)	Rwanda	Ministry of Gender and Family Promotion, Republic of Rwanda, 2004	
Traditional gender norms	Women whose partners preferred a boy child were 2.13 times as likely to experience violence in the pats year. (N=1306)	South Africa	Jewkes and Penn-Kekana, 2002	
Relationship				
Young age at marriage	Age at marriage is related to both ever and current experience of violence, though more significantly related to current experience of violence than ever-experiencing violence. The risk of violence declines as age at first marriage increases. For ever-experiencing violence, the odds ratios are: 15–19 years, OR=.72; 20–24, OR=.64, 25+, OR=.57. For current experience of violence, odds ratios are: 15–19 years, OR=.83; 20-24 years, OR=.74; 25+, OR=.57.	Zambia	Kishor and Johnson, 2004	Looked only at individual and relationship factors.
Young age at marriage	Among young women (ages 15–24), those who had ever been married were 2.6 times more likely to have experienced sexual coercion.	Kenya	Erulkar, 2004	

Risk Factor	Findings	Country	Source	Limitations
Friction over women's empowerment	Liberal ideas on women's roles also increased risk for violence. Those that submitted to personal subservience were only .9 times as likely to experience violence ever and .88 times as likely within the past year. (N=1306)	South Africa	Jewkes and Penn-Kekana, 2002	
Friction over women's empowerment	Women who had their own income were 1.48 time as likely to experience forced sex. (N=966)	Zimbabwe	Watts, Ndlovu, and Kwaramba, 1998	Looks only at individual and relationship factors.
HIV risk	Being HIV positive is associated with increased risk for sexual coercion for women (OR=1..89), while women who tried to negotiate condom use with HIV positive partners were 12.5 times more likely to experience physical violence.	Rwanda	Van der Straten et al., 1998	Difficult to ascertain the direction of the links between the factors.
HIV risk	Coercive sex was strongly related to perceptions of the male partner's HIV risk, with women who perceived their partner to be at highest risk, experiencing almost 3 times the risk of coercive sex relative to low risk partnerships. (OR=2.89 for very likely to have HIV and OR=2.32 for more likely to have HIV.)	Uganda	Koenig et al., 2004, in International Family Planning Perspectives	Special population in that the Rakai project sensitized women to HIV risk.
Male dominance in the family or relationship	56% of young women (15-24) who had experienced coercion had first partners who were 5 or more years older, compared with 46% of other young women.	Kenya	Erulkar, 2004	Statistical significance unclear.
Male dominance in the family or relationship	Women currently in relationships with high levels of male control were more likely to report recent and previous partner violence. (N=1366)	South Africa	Cited in Dunkle, 2004	
Male dominance in the family or relationship	Women who reported partner insistence on sex were more likely to report being beaten by 1.95 times.	Rwanda	Van der Straten et al., 1998	
Marital conflict	Frequent general conflict in the relationship resulted in 16.72 more violence for women within the year. (N=1306)	South Africa	Jewkes and Penn-Kekana, 2002	
Marital conflict	Separated and divorced women (15–24) were 4.7 times more	Kenya	Erulkar, 2004	

Risk Factor	Findings	Country	Source	Limitations
	likely to have experienced coercion than currently married young women who were living with their husbands.			
Non-monogamous partner	Women who knew their partners had a girlfriend were 2.43 more likely to experienced forced sex. (N=966)	Zimbabwe	Watts, Ndlovu, and Kwaramba, 1998	Looks only at individual and relationship factors.
Non-monogamous partner	Women whose partners had another sex partner were 4.53 times as likely to experience violence in the past year. (N=1306)	South Africa	Jewkes and Penn-Kekana, 2002	
Non-monogamous partner	Women whose partners were maintaining concurrent sexual relationships were 5 times more likely to have experienced physical violence than women who reported their partners never had other relationships. (N=245)	Tanzania	Maman et al., 2001	Focuses on individual and relationships factors. Cross-sectional rather than longitudinal study makes it impossible to determine the direction of the correlation.
Community				
Normative use of violence to settle disputes	Male involvement in physical conflict outside the home was associated with perpetration of sexual violence (OR=2.32). (N=1368)	South Africa	Abrahams et al., 2004	Sample, which consisted of men in lower socioeconomic categories, was not representative of all men in Cape Town.
Individual				
Educational status	Men who had not received post-school training were 3 times more likely to report perpetrating sexual abuse than those who had had such training. (N=1368)	South Africa	Abrahams et. al., 2004	Sample, which consisted of men in lower socioeconomic categories, was not representative of all men in Cape Town.
Educational status	Husband's of lower primary education level and those with no education were responsible for	Kenya	FIDA Kenya, 2002	Urban setting only

Risk Factor	Findings	Country	Source	Limitations
	most of the violence (41.7% of violence in the past year and 80% of lifetime violence). (N=1067 women)			
Educational status	Abusive partners were 3 times more likely to be illiterate than non-abusive partners.	South Africa	Araya, 2001	Statistical significance unclear
Educational status	Women with significantly higher levels of education (secondary school) reported more violence during the last year (25.4%) compared to women with no education or those with only primary education (17.8%). (N=1067 women)	Kenya	FIDA Kenya, 2002	Urban setting only
Educational status	Women with secondary schooling experience (5-8 years) had significantly lower risk of violence (OR=.66) than those with no education. (N=5109)	Uganda	Koenig et. al., 2003	Focuses on individual and relationship factors only.
Educational status	South African women are .29 times as likely to be beaten if they have a post-school education or 3.45 times as likely to be beaten with no post-school education. (N=1306)	South Africa	Jewkes and Penn-Kekana, 2002	
Educational status	The relationship between female education and coercion is curvilinear, with women with primary schooling significantly more likely to report coercion relative to the reference group of women with 8+ years of schooling (OR= 1.35). Uneducated women, in contrast, experience risks of coercive sex similar to those for the more educated group. (N=4279)	Uganda	Koenig et. al, 2004 in Studies in Family Planning	Special population in that the Rakai project sensitized women to HIV risk.
Female alcohol use	Drinking alcohol contributed to victimization (OR=2.55). (N=1306)	South Africa	Jewkes and Penn-Kekana, 2002	
Female alcohol use	Multiple regression analysis controlling for participant age, education, marital status and survey venue showed that women who had been sexually assaulted were 2.2 times more likely to	South Africa	Kalichman and Simbayi, 2004	Focuses on risk factors related to HIV risk. Survey was self-administered

Risk Factor	Findings	Country	Source	Limitations
	have used alcohol than those who had not been sexually assaulted. (N=272)			and definitions of sexual assault were limited.
Female alcohol use	Women's own consumption of alcohol before sex was modestly related to risk of violence (OR=1.22). (N=5109)	Uganda	Koenig, et. al., 2003	Focuses on individual and relationship factors only.
History of violence in the perpetrator's family	Men who received frequent beatings during childhood were 1.53 times more likely to be sexually violent; men who witnessed their mother being abused during childhood were 1.96 times likely to be sexually violent. (N=1368)	South Africa	Abrahams, et. al., 2004	Sample, which consisted of men in lower socioeconomic categories, was not representative of all men in Cape Town.
History of violence in the perpetrator's family	There was a strong correlation between the current physical violence and violence suffered in the perpetrator's childhood. (Chi-square=9.12, CI=.01, N=415)	Rwanda	Ministry of Gender and Family Promotion, Republic of Rwanda, 2004	Odds ratios not computed.
History of violence in the survivor's family	Experience of domestic violence in a woman's lifetime was positively associated with violence in her childhood. She is 1.93 more likely to be beaten if her mother was beaten and 1.64 times more likely to be beaten if she was frequently beaten as a child. (N=1306)	South Africa	Jewkes and Penn-Kekana, 2002	
Male alcohol use	Conflict over drinking alcohol was found to be a risk factor for violence within the past year (OR=3.98). (N=1306)	South Africa	Jewkes and Penn-Kekana, 2002	
Male alcohol use	Current problematic alcohol use (OR=2.28) and past problematic alcohol use (OR=2.03) were associated with the perpetration of sexual violence against intimate partners in the past 10 years. (N=1368)	South Africa	Abrahams, et. al., 2004	Sample, which consisted of men in lower socioeconomic categories, was not representative of all men in Cape Town.
Male alcohol use	The correlation between physical and sexual domestic violence and partners' alcohol use were found to be highly significant. (Physical:	Rwanda	Ministry of Gender and Family Promotion,	Odds ratios not computed.

Risk Factor	Findings	Country	Source	Limitations
	Chi-square= 15.053, CI=0.000, N=372; Sexual: Chi-square=5.591, CI=.018, N=371). Women respondents in focus groups (42.5%, N=449) agreed that male alcohol use was a "cause" of domestic violence.		Republic of Rwanda, 2004	
Male alcohol use	Women who reported alcohol consumption before sex by their male partner were more likely to experience coercive sex (OR=2.82 for frequent consumption and 1.57 for moderate consumption). (N=575)	Uganda	Koenig et al., 2004	Special population in that the Rakai project sensitized women to HIV risk.
Male alcohol use	Women whose partners drank alcohol or took drugs on most days were 1.4 times more likely to experience forced sex. (N=966)	Zimbabwe	Watts, Ndlovu, and Kwaramba, 1998	Looks only at individual and relationship factors.
Male alcohol use	Women whose partners frequently or always consumed alcohol before sex were 4.62 more likely to experience domestic violence than those whose partners never drank before sex. (N=5109)	Uganda	Koenig et al., 2003	Focuses on individual and relationship factors only.
Multiple sex partners by survivor	Multiple regression analysis controlling for participant age, education, marital status and survey venue showed that women who had been sexually assaulted were more likely to have 3 or more partners than those who had not been sexually assaulted. (OR=1.4) (N=272)	South Africa	Kalichman and Simbayi, 2004	Focuses on risk factors related to HIV risk. Survey was self-administered and definitions of sexual assault were limited.
Transactional sex	Women who had been sexually assaulted were more likely to exchange sex to meet survival needs than those who had not been sexually assaulted. (OR=5.2) (N=272)	South Africa	Kalichman and Simbayi, 2004	Focuses on risk factors related to HIV risk. Survey was self-administered and definitions of sexual assault were limited.
Transactional sex	Transactional sex was associated with broad intimate partner violence (OR=3.42), forced first	South Africa	Dunkle, 2004	

Risk Factor	Findings	Country	Source	Limitations
	intercourse (OR=1.24) and Sexual Relationship Power Scale, which measures male dominance in sexual relationships (N=1366).			
Young age	Women's age is shown to be a significant predictor, with younger women (<25 , OR=1.56 and 25–34 years, OR=1.34) significantly more likely to report having experienced sexual coercion relative to reference group of older women (aged 35+ years). (N=4279)	Uganda	Koenig et al., 2004 in Studies in Family Planning	Special population in that the Rakai project sensitized women to HIV risk.

ANNEX 2: SUMMARY OF PROMISING INTERVENTIONS

Promising Interventions	Typical Pitfalls and Lessons Learned
Health	
Attempts to change laws and policies	Mandatory reporting to law enforcement has also been said to make health providers hesitant to ask women about violence due to their fear of getting involved in legal entanglements.
Implementing a systems approach, including: Development and promotion of protocols to treat and respond to GBV victims with guidelines for collecting forensic evidence and provision of post-exposure prophylactics and emergency contraception for rape survivors. Infrastructure upgrades to ensure privacy and confidentiality.	Lack of training or enforcement of protocols and guidelines.
Training of health professionals at all levels. Providing staff resources such as screening tools and referral directories. Community mobilization activities to challenge gender inequalities related to reproductive health issues as well as gender-based violence.	Trainings are too short to achieve behavior change. Screening may not be appropriate in resource-poor settings that lack appropriate services. Untested messages, which in turn, do not reach their target audience effectively.
Behavior change communication for change around health and gender issues through radio, television, theater, pamphlets and other media efforts.	▪ Sessions are too short. Follow-up is required. ▪ Single-sex groups are more effective. ▪ Need trained facilitators. ▪ Failure to link behavior change with wider community mobilization.
Justice	
Legal reforms criminalizing violence against women.	▪ Laws not implemented. ▪ Light sanctions. ▪ Laws compromised by customary law.
Special units in police stations especially for violence against women.	Failure to integrate GBV in all law enforcement services.
Sensitization and training of judges and police on gender and gender-based violence.	▪ Lack of participation due to faltering institutional support. ▪ Continued attempts to reconcile victims with perpetrators.
Collaboration with various sectors in the community through referral systems.	Failure of women to arrive at other sites to which she was referred, e.g., from hospital to police station.
Educating women on their rights and available recourse and protection from violence.	In seeking legal recourse, women fear potential increase of violence or other repercussions from abusive partner and her family or community.
Youth/Education	
Efforts to change laws and policies on sexual harassment or abuse nationally, and specific to the schools system.	Policies remain as rhetoric.

Build teachers' knowledge of, capacity to respond to and incorporate GBV in their curriculum.	A "whole school" approach to training produces better results than select training of teachers or a train the trainers approach.
Female guardians to whom girls can report cases of sexual harassment and/or violence and receive counseling.	Programs for youth that seek to protect girls from abuse, may inadvertently reinforce the notion of girls as "victims."
Community awareness-raising through seminars and workshops with students, their parents, teachers, government officials and NGOs as well as the use of theatre and film for the youth community in general.	
Individual BCC with youth.	▪ Sessions are too short. Follow-up is required. ▪ Single-sex groups are more effective. ▪ Need trained facilitators. ▪ Failure to link behavior change with wider community mobilization.
Conflict/Refugee Settings	
Medical and counseling services for survivors, including forensic exams and post-exposure prophylactics. Legal aid for survivors and awareness raising on local laws. Teacher training in primary and secondary schools. Skills-building for women and girls. Mass media campaigns and awareness-raising among health providers and law enforcement. Training of all personnel on how to address GBV. Application of and awareness-raising of international law.	Interventions in conflict-affected or refugee settings are challenged because of the instability of governments, lack of infrastructure, on-going conflict and transitional nature of the population.
Multisectoral Coordination	
Networks that allow civil society organizations and others working on gender-based violence to share information and pool efforts to lobby government and changes laws and policies. Coordination of health, legal, psychosocial, educational and financial support services for survivors, or one-stop centers that provide most, if not all of these services. BCC/Community mobilization efforts that address multiple sectors.	Requires much effort to achieve cooperation and coordination between sectors and often between groups.

ANNEX 3. FIRST SEARCH DATABASES AND ORGANIZATIONAL WEBSITES SEARCHED

First Search Databases

1. AltpressIndex
2. ArticleFirst
3. BasicBiosis
4. BooksInprint
5. Contemporary Women's Issues
6. ECO
7. ERIC
8. PAISArchive
9. PAISInternational
10. PaperAbs
11. PapersFirst
12. Proceedings
13. WilsonSelect Plus
14. WorldCat

Websites

1. Alan Guttmacher Institute www.agi-usa.org
2. Amnesty International www.amnesty.org
3. www.afrol.com
4. CEDPA www.cedpa.org
5. Center for Law and Reproductive Policy www.CLRP.org
6. Center for Women's Policy Studies www.centerwomenpolicy.org
7. Family Health International www.fhi.org
8. Human Rights Watch, www.hrw.org
9. IGWG www.igwg.org
10. International Planned Parenthood Federation www.ippf.org
11. John Snow www.jsi.com
12. PATH www.path.org
13. Population Council www.popcouncil.org
14. Population Reference Bureau www.prb.org
15. RHRC www.rhrc.org
16. UNHCR www.unhcr.org
17. UNFPA www.unfpa.org
18. UNICEF www.unicef.org
19. UNIFEM www.unifem.undp.org
20. WHO www.who.int/en

ANNEX 4. RELATED LITERATURE REVIEWS

1. "Ending Violence Against Women" in *Population Reports* (Heise, Ellsberg, Gottemoeller, 1999)
2. "Intimate Partner Violence: Causes and Prevention" (Jewkes, 2002)
3. "Preventing and Responding to Gender-based Violence in Middle and Low-income Countries: A Global Review and Analysis" (Bott, Morrison, and Ellsberg, 2005)
4. Michau, Lori and Dipak Naker, Eds. (2004) Preventing Gender-based Violence in the Horn, East and Southern Africa: A Regional Dialogue. Raising voice and UN-Habitat Safer Cities Programme.
5. "Addressing Gender-Based Violence from the Reproductive Health/HIV Sector" (Guedes, 2004)
6. "Non-consensual sexual experiences of young people: A review of the evidence from developing countries" (Jejeebhoy and Bott, 2004)
7. "Unsafe Schools: A Literature Review of School-Related Gender-Based Violence in Developing Countries" (Wellesley Centers for Research on Women and DTS, 2003)
8. "Promotion of Initiatives to End Female Genital Mutilation." (Kessler, 2003)
9. *Data an Research on Human Trafficking: A Global Survey* (IOM, 2005)

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